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Children's Special Health Care Services
Guidance Manual for Local Health Departments

INTRODUCTION

Children's Special Health Care Services (CSHCS) has developed the Guidance Manual for Local Health Departments (LHDs) as a resource document for the LHDs. The Guidance Manual contains CSHCS program policy along with additional procedural information to enable the LHDs to assist CSHCS clients and enhance the working relationship between the LHDs and CSHCS.

CSHCS will send updated information to the Guidance Manual as it becomes available and/or as policies change. Sections within the manual, as well as some subsections, are designed so that entire replacement documents can be inserted without disturbing the continuity of the manual.

When using the manual, keep in mind the following:

- "MDCH" refers to the Department of Community Health, and "CSHCS" refers specifically to the CSHCS program.
- With the exception of headings and sub-headings, text that appears in blue-bold reflects CSHCS policy as published in the Children's Special Health Care Services Chapter of the Medicaid Provider Manual and the Comprehensive Planning, Budgeting and Contract (CPBC) Agreement. Additional information and procedures appear in regular text.
- Specific information related to covered services, prior authorization requirements, etc. should be obtained from the Medicaid Provider Manual, which is updated quarterly. The Medicaid Provider Manual can be accessed on the MDCH website: www.michigan.gov/mdch Click on "Providers".
- "Policy bulletins, draft policy, fee screens, and other pertinent information can be accessed on the website.
- All contact information can be found in Appendix A (Who to Call List) and Appendix B (MDCH Directory and CSHCS Directory). Addresses, phone numbers, etc. do not appear throughout the manual.
- Official forms (forms published by MDCH) related to CSHCS or referred to in the Guidance Manual are contained in Appendix D. Forms and informational sheets created by CSHCS for internal use are found at the end of the section that references their use.

SECTION 1: CSHCS MISSION STATEMENT

Children's Special Health Care Services (CSHCS) Program Mission

CSHCS strives to enable individuals with special health care needs to have improved health outcomes and an enhanced quality of life through the appropriate use of the CSHCS system of care.

Our goals are to:

- Assist individuals with special health care needs in accessing the broadest possible range of appropriate medical care, health education, and supports.
- Assure delivery of these services and supports in an accessible, family-centered, culturally competent, community-based, and coordinated manner.
- Promote and incorporate parent/professional collaboration in all aspects of the program.
- Remove barriers that prevent individuals with special health care needs from achieving these goals

SECTION 2: CSHCS PROGRAM OVERVIEW

2.1 General Program Description

Children's Special Health Care Services (CSHCS) is a program within the Michigan Department of Community Health (MDCH) created to find, diagnose, and treat children in Michigan who have chronic illnesses or disabling conditions. CSHCS is mandated by the Michigan Public Health Code, Public Act 368 of 1978, in cooperation with the federal government under Title V of the Social Security Act and the annual MDCH Appropriations Act. CSHCS promotes the development of service structures that offer specialty health care for the CSHCS qualifying condition that is family centered, community based, coordinated, and culturally competent.

MDCH covers medically necessary services related to the CSHCS qualifying condition for individuals who are enrolled in the CSHCS Program. The CSHCS population consists of persons under the age of 21 with one or more qualifying medical diagnoses. It also includes persons age 21 and older with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia**.** **Medical eligibility must be established by MDCH before the individual is eligible to apply for CSHCS coverage. Based on medical information submitted by providers, a medically eligible individual is provided an application for determination of non-medical program criteria** (citizenship, residency, etc.).

CSHCS does not cover primary care, well child visits, immunizations, substance abuse services, or services provided by long term care facilities. In addition, CSHCS does not cover the treatment service needs related to developmental delay, mental retardation, autism, psychiatric, emotional, behavioral, or other mental health diagnoses.

The CSHCS Program does not issue "Emergency Services Only" coverage. The program issues coverage for services related to the CSHCS qualifying diagnosis(es) to those who are medically eligible, meet all of the program requirements, and complete the application process.

An individual may be eligible for CSHCS and eligible for other medical programs such as Medicaid, Adult Benefit Waiver I (ABW I), Medicare, or MIChild. To be determined dually eligible, the individual must meet the eligibility criteria for CSHCS and for the other applicable program(s).

NOTE: When a CSHCS enrollee is also eligible for Medicaid and needs a service that is covered by both programs, the Medicaid coverage, benefits and rules take precedence over CSHCS. Any additional benefits available to the individual through CSHCS coverage are allowed and conducted according to CSHCS policy.

2.2 Family-Centered Care

The CSHCS program (and every state's program legislated by Title V of the Social Security Act) has a strong commitment to family centered care. The Institute for Family Centered Care defines the term as follows:

> "Family-centered care is an approach to health care that offers a new way of thinking about the relationships between families and health care providers. Family-centered providers recognize the vital role that families play in ensuring the health and well being of infants, children, adolescents, and family members of all ages. Family-centered practitioners assume that families, even those who are living in difficult circumstances, bring important strengths to their health care experiences.
>
> "Family-centered practitioners acknowledge that emotional, social, and developmental support are integral components of health care. A family-centered approach to care empowers individuals and families and fosters independence; supports family care giving and decision making; respects patient and family choices and their values, beliefs, and cultural backgrounds; builds on individual and family strengths; and involves patients and families in planning, delivery, and evaluation of health care services. Information sharing and collaboration between patients, families, and health care staff are cornerstones of family-centered care."

For more than two decades, Michigan's CSHCS program has earned national recognition for the way family centered care is woven into all facets of its operations. Notably, CSHCS includes a parent of a child with special needs on its management team. The impact is that "the family point of view" influences all CSHCS policies, procedures, communications, and day-to-day operations.

Therefore, CSHCS has institutionalized the collaboration of families and professionals. This partnership shapes policies and programs to improve care and support for children with special needs and their families. Such a collaborative approach "humanizes the service delivery system, improves outcomes for children and results in greater satisfaction for both providers and families."

With the goal of extending such spirit of collaboration into all of its initiatives, LHD staff is encouraged to tap the Family Center for CYSHCN for both the support it can offer to help solve a family's CSHCS problems and as a referral resource. See Section 5 for more information.

Family centered care includes the use of "people first" language. A federal fact sheet that addresses people-first language and tips on communicating with and about persons with special needs and disabilities can be accessed. See Appendix A for contact information.

2.3 Healthy People 2010

The U.S. Department of Health and Human Services' Healthy People 2010 initiative challenges individuals, communities, and professionals to take specific steps to ensure that good health, as well as long life, are enjoyed by all. Michigan is working to fulfill these objectives by collaborating with families, insurers, government, medical educators and other components of the health care system to improve the quality of life for children with special health care needs.

The Healthy People 2010 Goals for Children and Youth With Special Health Care Needs are described below.

Goal 1: Families of children with special health care needs will partner in decision making at all levels and will be satisfied with the services they receive.

The physician is knowledgeable about the needs of the child and family, and recognizes that the family is the principal caregiver and the center of strength and support for the child. The family receives clear and complete information and options, shares in the responsibility for decision making, and has a central role in care coordination. Concern for the well being of the child and family is expressed and demonstrated, showing empathy for the feelings of the child and family.

Goal 2: All children with special health care needs will receive coordinated, ongoing, comprehensive care within a medical home.

A medical home is a way of providing care that is accessible, family-centered, comprehensive, continuous, coordinated, compassionate, and culturally competent. In a medical home, the physician works in partnership with the client and family to assure that all of the medical and non-medical needs of the client are met. Through this partnership, the physician can help the client or family access and coordinate specialty care, educational services, out-of-home care, family support, and other private and community services that are important to the overall health of the client and family.

Goal 3: All families of children with special health care needs will have adequate private and/or public insurance to pay for the services they need.

Information is available to families regarding private insurance and public resources. Providers accommodate changes in insurance, and all insurances including Medicaid, are accepted.

Goal 4: All children will be screened early and continuously for special health care needs.

Screening is performed on an ongoing basis to identify special health care needs, and ensure timely and appropriate follow up for those who screen positive. Children identified with special health care needs receive ongoing monitoring for secondary conditions.

Goal 5: Community-based service systems will be organized so families can use them easily.

Health care is delivered or directed by a well-trained, community physician, and is available 24 hours a day, seven days a week. Care is provided in the client's community and is accessible by public transportation. Families are linked to support, educational, and other community based services through a coordinated plan of care that is developed by a physician, client, and family.

Goal 6: All youth with special health care needs receive the services they need to make appropriate transitions to adult health care, work, and independence.

Family and youth are supported to play a central role in care coordination, and share the responsibility for decision making. Physicians are available to speak directly to youth and family when needed, and provide assistance with transitions in the form of developmentally appropriate health assessments and counseling. Care coordination for the adult client refers to and includes identification of the client's needs as a whole, the offer of assistance, and/or referral to other community resources as needed.

2.4 Medical Home

The U.S. Department of Health and Human Services' Healthy People 2010 goals and objectives state that "all children with special health care needs will receive regular ongoing comprehensive care within a medical home." Michigan is working to fulfill this objective by collaborating with families, insurers, government, medical educators and other components of the health care system to improve the quality of life for children through the care provided in a medical home.

A medical home is an approach to providing comprehensive care that is:

- **Accessible:** Care is provided in the client's community, is accessible by public transportation, and accepts all insurances
- **Family centered:** Recognition that the family is the principal caregiver and the center of strength and support for children, shares in the responsibility for decision making, and is has a central role in care coordination
- **Continuous:** The same pediatric health care professionals are available from infancy through adolescence and young adulthood and able to provide assistance with transitions
- **Comprehensive:** Health care is delivered or directed by a well-trained physician, and care is available 24 hours a day, seven days a week
- **Coordinated:** Families are linked to support, educational, and other community based services through a plan of care that is developed by a physician, client, and family
- **Compassionate:** Concern for the well being of the child and family is expressed and demonstrated, showing empathy for the feelings of the child and family
- **Culturally competent:** The family's cultural background is recognized, valued, respected and incorporated into the care plan

In a medical home, a pediatric clinician works in partnership with the client/family to assure that all medical and non-medical needs of the client are met. Through this partnership, the pediatric clinician can help the client/family access and coordinate specialty care, educational services, out-of-home care, family support, and other private and community services that are important to the overall health of the client and family.

For more information about medical home refer to the American Academy of Pediatrics website. See Appendix A for contact information.

2.5 Transition

The U.S. Department of Health and Human Services' Healthy People 2010 goals and objectives state "all youth with special health care needs receive the services they need to make appropriate transitions to adult health care, work, and independence." Michigan is implementing this objective by collaborating with youth, families, providers, and professionals. Through these collaborative efforts Michigan is working toward providing education about the process of transition, coordinating systems of care, and creating tools to begin transition planning for all aspects of adult life such as; health care, employment, and independence.

Transition to adult life includes:

- **Health Care:** As youth with special health care needs become adults they must make the transition from the pediatric health care system to the adult health care system. This includes, obtaining adequate medical insurance, learning independent health care skills, and locating adult providers willing to provide care.
- **Employment:** The Maternal and Child Health Bureau has started an initiative for children with special health care needs entitled "Healthy and Ready to Work." The guiding principle behind this initiative is that youth with special health care needs must maintain their health in order to be successful in employment and be self-sufficient. For more information on this initiative visit the Healthy and Ready to Work website. See Appendix A for contact information.
- **Independence:** As youth with special health care needs transition from adolescence to adult life they must have developmentally appropriate skills for independent living. This includes skills such as, maintaining a savings account, paying bills, cleaning a home, and making meals.

In order to be successful in planning for the transition to adult life, many people, agencies, and organizations may be involved. Planning should address the transition from pediatric to adult health care systems that are developmentally appropriate, secondary to post-secondary education or employment, and dependence to self-sufficiency. As youth approach adulthood the process of transition should provide them with tools and resources to increase their ability to lead productive and successful adult lives.

SECTION 3: HISTORY OF CSHCS

The people of the State of Michigan and their legislators have a long history of concern for children with special health care needs. This concern has been translated into a state and federally supported program, which has as its goal the achievement of the fullest potential for each child with special health care needs in Michigan.

The Michigan Crippled Children Program was initiated by the State Legislature in 1927, although services to this population can be traced back to the year 1881. Public Act 236 of 1927 established the Michigan Crippled Children Commission as the official state agency for the program. The agency's task was to locate, examine, and treat children with special health care needs for the purpose of making them self-sustaining to the extent possible rather than "charges on the public" for support.

The program was federally mandated by Title V of the Social Security Act, which was originally approved on August 14, 1935. Title V is commonly referred to as the Maternal and Child Health Services Block Grant. Section 501 (D) of Title V authorizes appropriations enabling each state

> "to provide and to promote family-centered, community-based, coordinated care (including care coordination services) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families."

With the passage of Public Act 158 of 1937 (commonly referred to as the Crippled Children Act), the powers and duties of the Michigan Crippled Children Commission were expanded. The new focus was to develop, extend, and improve services for locating such children, to provide for medical, surgical, corrective, and other services and care, and to provide for facilities for diagnosis, hospitalization, and special education.

In 1944, Dr. James T Pardee, a founder of Dow Chemical, made a generous bequest of Dow Chemical Company stock to support children with special needs. This marked the beginning of the Crippled Children's Fund, known today as the Children with Special Needs (CSN) Fund. See Section 24 for information on the CSN Fund.

In 1965, the Michigan Crippled Children Commission became part of the Michigan Department of Public Health under the Executive Reorganization of that year. An administration of the Crippled Children Program was transferred totally to the Bureau of Community Services, Division of Services to Crippled Children (DSCC).

Public Act 368, Part 58, of the Public Acts of 1978 (commonly known as the Michigan Public Health Code) replaced the Crippled Children Act and provides for the "medical, surgical, corrective, nutritional, and other services and care, including aftercare when necessary, and facilities for diagnosis and hospitalization of crippled children". With the institution of the Public Health Code, the Michigan Crippled Children Commission was replaced by the newly created Crippled Children Advisory Committee, created to "confer with and advise the department as to its functions under this part".

The Program has always been committed to removing barriers to appropriate health care so that children with special health care needs may grow and develop to their full potential. This commitment led to a comprehensive review of the Division of Services to Crippled Children in 1982 and 1983. This review resulted in several recommendations, including the strengthening of services on a local level, which was regarded as DSCC's first priority. The implementation of Locally Based Services (LBS) was expected to improve case finding, case planning, and case management services to Michigan children with eligible qualifying conditions or chronic illness.

1988 brought forth the initiation of the Parent Participation Program (PPP), now known as the Family Center for Children and Youth with Special Health Care Needs (Family Center for CYSHCN), Michigan's prominent Title V family-centered care initiative. PPP was a national innovation to employ a parent of a child with special health care needs to represent families on the Title V administrative team. Today, numerous Title V programs nationwide have adopted the concept. See Section 5 for more information about the Family Center for CYSHCN.

Also in 1988, PPP was influential in approaching DSCC about changing the name of the Crippled Children's Program. The major focus of the concern was the use of the term "crippled" which had a negative connotation in the minds of the public, and does not accurately describe all the conditions covered by the program. After much discussion, a new name was chosen for the purpose of communication with the public and providers. However, the term "Division of Services to Crippled Children" was retained for statutory and legislative purposes as the title of the organizational entity since this name had a well-known identity in achieving funding support. The title "Children's Special Health Care Services" was used to describe the broad scope of services provided by the program. Over a period of time, Children's Special Health Care Services (CSHCS) became more widely used and eventually replaced the former name "Crippled Children".

Due to the Executive Reorganization of 1996, CSHCS, as part of the Department of Public Health, merged with the Department of Mental Health and the Medical Services Administration (Medicaid) of the Department of Social Services to become the newly created Michigan Department of Community Health (MDCH). CSHCS became part of the Medical Services Administration (MSA), along with the Medicaid program.

Also in 1996, the Public Health Code was amended to remove the requirement and conditions of the Crippled Children's Advisory Committee, and transferred the powers and duties to the Director of the MDCH. By choice, the CSHCS Division continues to organize and support the CSHCS Advisory Committee. The by-laws of the committee as approved in 2003 call for at least one-third consumer representation. The committee typically meets bi-monthly and advises the CSHCS Division on all aspects of the program.

The year 2002 brought forth another restructuring of MDCH. At this time, CSHCS was moved out of MSA and became part of the MDCH Public Health Administration.

In 2003, the CSHCS Division created an Ad Hoc Advisory Committee specifically and solely to receive input from the CSHCS staff at the LHDs. 15 LHD professional staff members were appointed to work with the CSHCS Director to develop, implement, evaluate, and revise components of the CSHCS program. The committee continues to function in that role and is now called the CSHCS Local Advisory Council (CLAC).

SECTION 4: CSHCS ORGANIZATIONAL STRUCTURE

As of 2003, the Children's Special Health Care Services Division is part of the Bureau of Family, Maternal, and Child Health, in the Public Health Administration (PHA) of the Michigan Department of Community Health (MDCH).

4.1 CSHCS Program Sections and Responsibilities

The CSHCS Division contains the following management sections:

- Children with Special Needs Fund (CSN)
- Customer Support Services
- Family Center for Children and Youth with Special Health Care Needs (Family Center for CYSHCN)
- Policy and Program Development
- Quality and Program Services

4.1-A Children with Special Needs (CSN) Fund

- Provide services and equipment to children with special health care needs that no other resource, including state or federal programs, provides
- The child must be under age 21 and a Michigan resident to receive benefits from the CSN Fund
- The child must be enrolled, or medically eligible to enroll in the CSHCS Program to be eligible for assistance through the CSN Fund (See Section 18)

4.1-B Customer Support Section (CSS)

- Assign a specific analyst to work with each county
- Process medical eligibility determinations. Medical eligibility determinations are made by the Office of Medical Affairs (OMA)
- Process program applications
- Process providers authorized by OMA onto the system
- Conduct financial assessments and audits
- Determine and implement payment agreements
- Issue and renew client program coverage
- Maintain current client information on the CSHCS Oracle database (i.e. address, diagnoses, etc.)

- Represent CSHCS in the appeals process as appropriate
- Maintain custody and security of client protected health information (PHI)

4.1-C Family Center for Children and Youth with Special Health Care Needs (Family Center for CYSHCN)

The Family Center for CYSHCN is a parent-directed program of CSHCS. The responsibilities of the program are as follows:

- Assure that CSHCS program policies and practices reflect the needs and priorities of families who have children with special health care needs
- Maintain a communication system between the CSHCS program and families of children with special health care needs
- Assure that families of children with special health care needs have access to a responsive network of peer support that includes matching individual families with similar circumstances
- Assist in educating families of children with special health care needs by providing information for families to help them identify options to meet the needs of their child and family and make informed decisions regarding their child's health care
- Conduct workshops and other training and information opportunities for families of children with special health needs
- Assist families in addressing inquiries or problems via the toll-free CSHCS Family Phone Line (see Appendix A)

4.1-D Policy and Program Development Section

- Develop, implement and revise program policies
- Develop CSHCS data collection and analysis for application to policy development
- Research, advise, recommend and assist with implementation of program development plans
- Develop transition planning strategies for various CSHCS sub-populations
- Administer non-CPBC Contracts
- Assist LHDs and families with complex billing/reimbursement problems

4.1-E Quality and Program Services Section

- Assure program quality and improvement planning
- Coordinate and manage CSHCS forms

- Monitor CSHCS customer satisfaction
- Determine authorization of requests for Hospice and Respite
- Monitor Comprehensive Planning, Budgeting and Contract (CPBC) Agreement requirements
- Monitor the CSHCS office operations in the Local Health Departments
- Administer the insurance premium payment program
- Schedule out-of-state travel
- Prepare case documentation for Departmental Reviews and Administrative Hearings
- Administer the Children's Multidisciplinary Specialty (CMS) Clinic contracts
- Monitor the CMS clinic providers and operations
- Organize and conduct LHD meetings and trainings, including new employee orientation for local CSHCS programs

4.2 Office of Medical Affairs

The Office of Medical Affairs (OMA) is part of the Medical Services Administration within MDCH. The CSHCS medical consultants operate out of OMA. OMA and CSHCS are in continual collaboration regarding all aspects of the CSHCS program. Contact information for OMA is listed in Appendix A and Appendix B.

OMA maintains the responsibility for:

- Reviewing medical reports and determining medical eligibility
- Representing CSHCS at Department Reviews regarding appeals of medical eligibility decisions
- Providing consultation regarding all aspects of CSHCS

SECTION 5: FAMILY CENTER FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (FAMILY CENTER FOR CYSHCN) – (formerly known as Parent Participation Program, name changed 10-1-06)

5.1 History and Description

The Family Center for CYSHCN is a section of the CSHCS Division. It is Michigan's prominent Title V family-centered care initiative. In 1988, when Michigan CSHCS launched the Parent Participation Program, it was a national innovation to employ a parent of a child with special health care needs to represent families on the Title V administrative team. Because of the trial's success, numerous Title V programs nationwide have adopted the concept.

The Family Center is comprised primarily of parent consultants who have children with special health care needs. Staff is located in the Family Center's Lansing and Detroit offices, and includes a home-based part-time coordinator of the statewide parent-to-parent network. The Family Center's primary functions are to help shape CSHCS policies and procedures, help families navigate the CSHCS and Medicaid systems, and through its Family Support Network of Michigan, provide information and emotional support to all Michigan families of children with special health care needs.

The MDCH Comprehensive Planning, Budgeting, and Contracting (CPBC) Agreement requires the LHDs to "assure that the strengths and priorities of families are integrated into all aspects of the health care system by facilitating the direct participation of families in program development, implementation, evaluation, and policy formation". The LHDs can assist in accomplishing those goals by encouraging parents to use resources provided by the Family Center or take part in the Family Center's activities.

5.2 Program Services and Support

The Family Center answers the toll-free CSHCS Family Phone Line (see Appendix A), from 8 a.m. to 5 p.m. Monday through Friday. Operators can transfer families to any CSHCS office, including those in the LHDs. The Family Center operators can help resolve a CSHCS problem by explaining a process or by transferring the caller to the appropriate party for answers to their questions. Operators can answer basic enrollment inquiries, such as dates of service and listed providers, by looking up information on the MDCH Oracle system. Additional information for using the Family Phone Line can be found at the end of this section.

For any call, families who prefer to speak a language other than English can access a translator. The Family Center operators can immediately connect to the Language Line, a company that provides over-the-phone translators who speak dozens of languages. See Section 6 for more information. The subscription to Language Line extends to all CSHCS offices in the LHDs.

CSHCS members or their parents also may use the CSHCS Family Phone Line to:

- Contact their CSHCS medical provider.
- Reach the Family Support Network of Michigan (FSN), The Family Center statewide parent-to-parent support arm for families of children with special needs.

Talk with a FSN support parent for up to 30 minutes

LHDs are encouraged to make the Family Center aware of family members interested in volunteering to serve on committees to improve special health care. The Family Center offers support service to parent volunteers, such as reimbursement of mileage and child care expenses, as they are serving on CSHCS advisory bodies.

Additional Family Center services include:

- Administration of scholarships (financed by the CSN Fund) for parents to attend conferences related to the medical condition of their child with special needs.
- Coordination of the Family Support Network of Michigan (FSN). It is the Family Center's statewide network of families of children with special needs. According to national research, one of the most helpful experiences for parents of children with special needs is to talk with someone else who has "been there." The Family Center matches parents who are new to the world of special needs to veterans who want to help. In addition, the Family Center offers support parent training to veteran parents, following national standards of "best practices."
- Maintains the "Family Guide to Michigan's Children's Special Health Care Services Program". The Family Guide is included with the application packet that is sent to all families who are invited to join CSHCS. Additional copies of the Family Guide may be obtained by contacting the Family Center (see Appendix A).

The Family Center helps keep parents informed on issues related to children with special needs. A monthly newsletter called "Heart-to-Heart Update" provides information about CSHCS policies and procedures, FSN news, general events information and resource listings. The Family Center also offers a Lending Library of books, magazines and other items of interest to families of children with special needs. "Heart-to-Heart Updates" can be accessed on the CSHCS website (see Appendix A).

The Family Center is a resource for bereavement information for families who have experienced loss. For parents and other family members who would like help in coping with the loss of a child, the Family Center offers a packet of bereavement information.

"Relatively Speaking" is a bi-annual conference sponsored by the Family Center for siblings of children with special needs. In a weekend conference, young brothers and sisters of children with special needs participate in a "Sibshop", which is a special set of age-appropriate, fun activities led by specially trained adults. Concurrently, children with special needs attend age-appropriate activities. In separate tracks, parents and other adult family members attend workshops to gain a deeper understanding and appreciation for the sibling aspect of living in a family of a child with special needs. "Relatively Speaking" is thought to be the only conference of its kind in the nation offered by a parent program associated with a state government program for children with special needs.

Family Center for Children and Youth with Special Health Care Needs (Family Center for CYSHCN)
Children's Special Health Care Services Plan Division (CSHCS)
Michigan Department of Community Health

Family Center for CYSHCN is a parent-directed section of the Children's Special Health Care Services Plan Division, Michigan Department of Community Health. The purposes of Family Center for CYSHCN are:

- to bring consumer input into CSHCS program and policy development;
- to establish a community-based parent-to-parent support network for families of children with special health needs;
- to facilitate parent/professional collaboration at all levels of health care.

The driving force behind all Family Center for CYSHCN activities is the realization of family-centered, culturally competent, community-based, coordinated care for children and families.

Family Center for CYSHCN Services Include:

- Supports for families to participate in CSHCS program and policy development
- CSHCS Family Phone Line **(1-800-359-3722)**
- Consultation to CSHCS
- Information for grandparents, siblings, fathers and bereaved families of children with special needs
- Input into national health care issues

Monthly newsletter on CSHCS and other health issues of interest to families of children with special needs

- A statewide parent-to-parent Family Support Network
- Education on culturally competent care and encouragement of its use
- Parent/Professional training programs
- A Relatively Speaking, at a conference for siblings of children with special needs
- Scholarships for parents to attend conferences related to the medical condition of their child with special needs
- Helps youth transition to adult health care

Who Should Use The CSHCS Family Phone Line? The CSHCS Family Phone Line is for parent use only. Parents or guardians can call **1-800-359-3722** to:

- Call the CSHCS office in any local health department

***Note:* We are not funded to transfer callers to other agencies such as Community Mental Health, the Human Services Agency, schools, ISDs, Head Start Offices, Friend of the Court, and other court offices.**

- Make a call to CSHCS staff in the Lansing office
- Obtain general information on how to join CSHCS
- Resolve problems related to CSHCS
- Contact their CSHCS medical provider(s)
- Contact the Family Support Network of Michigan
- Reach their FSN Support Parent for up to 30 minutes

The CSHCS Family Phone Line (1-800-359-3722) is answered Monday through Friday, 8am - 5pm.

(Family Center for CYSHCN), Cadillac Place, Suite 3-350, 3056 W. Grand Blvd., Detroit, Michigan 48202
phone: 313-456-4381 g: Family Center for CYSHCN.07-05

Family Phone Line Policy

- Length of Incoming Transfer Calls:

  Calls should last less than 30 minutes

- Family Center for CYSHCN

The Family Center for CYSHCN staff can ask the following questions to incoming callers:

- Is your child on our program (CSHCS)?
- What is your child's diagnosis?
- What is your child's ID number?
- Have you been matched with another parent for parent-to-parent support?

For any caller who consistently makes calls lasting 30 minutes, the Family Center for CYSHCN staff will follow this procedure:

First Month: Call the individual, reiterate the purpose of the line and explain the 30 minutes maximum call policy.

Second Month: The director will send a reminder letter

Third Month: Family Center for CYSHCN will send a letter asking for reimbursement of the calls

The Family Phone Line is not to be used by husbands and wives/relatives and/or other family members that use the Family Phone Line to speak to each other daily. This line should only be used in this way, in an emergency regarding their child.

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SECTION 6: ROLE OF THE LOCAL HEALTH DEPARTMENTS (LHD)

Local Health Departments (LHD) throughout the state are committed to serving children with special health care needs in the community. The CSHCS office in the LHD acts as an agent of the CSHCS program at the community level. It is through the LHDs that CSHCS succeeds in achieving its charge to be community based. The LHD serves as a vital link between the CSHCS program, the family, and the local community, to assure that children with special health care needs receive the services they require. CSHCS offices are located in every LHD, covering every county of Michigan and the City of Detroit.

According to CPBC requirements described in Section 7, the LHDs are required to provide the following specific outreach and advocacy services:

- Program representation and advocacy
- Application and renewal assistance
- Link families to support services (e.g. Family Center for CYSHCN, Family Phone Line, or Family Support Network, transportation assistance)
- Implement any additional CPBC requirements
- Care coordination

The CPBC strongly encourages, but does not require Case Management at this time.

Case Management and Care Coordination are billed separately through the Financial Status Report (FSR) that the LHDs use to obtain funding from MDCH. When the LHD provides case management and/or care coordination, the policies, procedures, and billing instructions described in Section 13 and Section 14 must be followed.

As a community resource the LHD plays a major role in providing outreach and assistance to families at the local level including, but not limited to, the following:

- Locate and assist families who do not complete and return a streamlined application or renewal paperwork.
- Arrange diagnostic evaluations.
- Assist with obtaining medical reports for determination of medical eligibility.
- Provide program information on medical eligibility, program coverage periods and covered services.
- Provide information on and assistance with the CSHCS Insurance Premium Payment Program and the CSN Fund Application.
- Refer to and assist with application for other programs such as Early On, WIC, MIChild and Healthy Kids.

- Assist with completion of the CSHCS application, financial assessment, and third party liability forms.
- Obtain documentation from families indicating legal guardianship, citizenship, etc. when needed to determine status for program purposes.
- Contact newly enrolled families to share information, perform a needs assessment, and document care coordination activities and follow-up as needed. The CSHCS Service Needs Summary Record (MSA-0741, see appendix D) and the CSHCS Service Needs Questionnaire (MSA-0743) may be useful tools to aid in this process, but specific forms are not required.
- Assist families in accessing other services within the LHD, such as family planning services, Maternal Infant Health Program (MIHP), etc.
- Assist clients who age out of CSHCS and their families during the process of transitioning to adult services.
- Assist families in accessing CSHCS service benefits (Hospice, Home Health, etc.).
- Facilitate linkage to community resources (e.g. Community Mental Health [CMH], Intermediate School District [ISD]) as needed.
- Assist families with the guardianship process as needed prior to the client turning age 18.
- Provide Case Management and Care Coordination services.

Provide information about CMS clinics and other providers.

6.1 LHD Resources

Several resources are available to the LHDs to assist in working with families, to provider education and information for LHD staff and/or families, and to update the LHDs on new and changing information and policies. The resources are described below.

6.1-A Language Line

The LHD may encounter situations where the family does not speak English and requires an interpreter. LHDs that have a conferencing feature on their office telephones can connect directly to the Language Line. Direct connection to the Language Line is the most efficient way to use this service.

To connect directly to the Language Line, follow these instructions:

- Use the “Conference Hold” feature to place the non-English speaker on hold
- Dial 1-800-874-9426
- Press “1” for Spanish; press “2” for all other languages. You may also press “0” or stay on the line for assistance

- Enter on the telephone keypad or provide the Language Line representative with these three items:
  - This 6-digit client ID number: 508018
  - Organization name: Children's Special Health Care Services
  - Personal code: 2-digit county code followed by the CSHCS staff member's telephone number

An interpreter will be connected to the call. Brief the interpreter, summarize what is intended to be accomplished and provide any special instructions. Then add the non-English speaker to the line.

When placing a call to a non-English speaker, begin at step 2 and proceed as directed. If assistance is required when placing a call to a non-English speaker, press "0" to be transferred to a representative at the beginning of the call.

LHDs who do not have a conferencing feature on their office telephones can call the Family Phone Line, and the caller and the member are transferred to the Language Line.

The above directions and additional information can be found on the Language Line website. See Appendix A for contact information.

For anyone interested in knowing more about the CSHCS program, as well as other programs within MDCH, educational and information is provided through mihealth training. The training is an on-line resource offering a variety of courses suitable for providers, staff, and families.

6.1-B Mihealth Training

Several internet based courses for LHDs, health care providers, staff, and families are available through mihealth training. The courses provide information and education on topics such as breast and cervical cancer control, newborn screening, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Michigan Care Improvement Registry (MCIR), HIPAA transactions, and UB-92 and HCFA-1500 claim forms.

Courses are also available that provide a basic overview of CSHCS, Medicaid, and Medicaid managed care. These on-line courses are excellent resources for families who would like basic information about these programs. See Appendix A for contact information.

6.1-C Local Liaison Report (LLR)

The LLR is produced through the cooperative efforts of various human services program staff and provides information to local health departments, forums, state agencies, and others regarding services, programs, and topics of interest. Current and past LLRs can be accessed electronically on the MI-TRAIN website. See Appendix A for contact information.

SECTION 7: COMPREHENSIVE PLANNING, BUDGETING, AND CONTRACT (CPBC)

7.1 Background

CPBC is the contract between MDCH and LHDs. It includes all programs for which MDCH contracts with the LHDs.

CSHCS program requirements for Outreach and Advocacy are included in Attachment III of the contract, "Special Requirements for CSHCS". CSHCS does not have minimum program requirements as are found with most MDCH programs as CSHCS is not monitored through the accreditation process at this time.

Annual reporting is required through a written narrative report as well as an output report as described in Attachment III of the CPBC contract. At the beginning of the fiscal year, CSHCS offices in the LHDs must submit projected numbers to be achieved during the fiscal year for the number of diagnostic evaluations, the number of families directly assisted with the CSHCS application process, and the number of families directly assisted with the CSHCS renewal process. After the end of the fiscal year, the LHDs report the actual number of people served for each of those reporting elements; therefore, the LHD must have tracking systems in place in order to submit an accurate report.

7.2 Funding

Every LHD in Michigan receives a set amount of money from MDCH to provide CSHCS outreach and advocacy services within their jurisdiction. The required services are specified in Attachment III of the CPBC contract, "Special Requirements for CSHCS", included in this section.

7.3 FISCAL YEAR CPBC, Attachment III Special Requirements

CSHCS SPECIAL REQUIREMENTS

Contractor Requirements

LHDs throughout the state act as an agent of the CSHCS program in achieving its charge to be community based and to assure that children with special health care needs receive the services they require. CSHCS offices located in every LHD, covering every county of Michigan and the City of Detroit must employ adequate personnel to serve the CSHCS clients within the respective counties (jurisdiction). LHD must designate minimum FTE nurse and Representative (clerical) staff based on the following funding ranges:

Funding Ranges	Nurse FTE Minimum	Rep. FTE Minimum
$28,000-$40,000	0.25 FTE	0.25 FTE
$80,000-$113,000	1.0 FTE	0.50 FTE
$172,000-$285,000	2.0 FTE	1.0 FTE
$565,000-$680,000	4.0 FTE	3.0 FTE

All of the following activities must be implemented according to CSHCS issued policy.

1. Program Representation and Advocacy

   A. Actively promote outreach and program representation which includes, but is not limited to the provision of information regarding Children's Special Health Care Services (CSHCS) policy on diagnostic referrals, program eligibility, covered services, prior authorization, and the appeals process to local hospitals, providers, the community, other agencies and families.

   B. Inform families of their rights and responsibilities in the CSHCS program.

   C. Describe CSHCS benefits to families, including, but not limited to, the Children with Special Needs (CSN) Fund, the insurance premium payment benefit, skilled nursing respite, hospice and out-of-state care, and assist as needed.

   D. Actively promote and provide information, referral, and assist persons in making applications for other programs in the community for which the child and/or family may be eligible, such as Early On, WIC, MIChild, Healthy Kids, Medicaid, and Medicare.

   E. Actively promote and provide assistance to help families advocate on their own behalf. Serve as a liaison with service providers as needed.

   F. Assure that family centered care is integrated into the local CSHCS system of care by facilitating the direct participation of families in program development, implementation, evaluation and policy formation.

2. Application and Renewal

A. Assist with medical eligibility determination by arranging diagnostic evaluation referrals or obtaining Release of Information form(s) for the purpose of securing medical reports for determining medical eligibility.

B. Assist any family who is referred or who contacts the local health department for assistance with completion of the CSHCS application form, Income Review/Payment Agreement form, and third party liability forms.

C. Initiate a welcome contact to newly enrolled CSHCS families.

D. Contact CSHCS enrolled families at least annually to provide information about the CSHCS program, assess family needs and update client information.

E. Locate individuals or families who do not return a CSHCS Application within 30 days after being made medically eligible, and offer assistance with application completion.

3. Support Services

A. Refer families to the CSHCS Family Center for Children and Youth with Special Health Care Needs (referred to as the "Family Center and previously known as the Parent Participation Program) and actively promote the Family Phone Line and the Family Support Network.

B. Facilitate transition through the Medicaid Health Plan (MHP) process and into the MHP environment for CSHCS/Medicaid clients prior to and up to six months after aging out of CSHCS (at age 21) if needed.

C. Assist and authorize in-state travel assistance for CSHCS families as needed.

D. Contact families when a referral is made or when the Customer Support Section initiates a "Notice of Action" request to locate or assist a family.

E. Provide care coordination to CSHCS families as needed, according to current CSHCS policy and procedures.

4. Case Management Requirements

When local health departments provide CSHCS case management services, the most current case management policy and procedures as established by CSHCS must be followed.

5. Reporting Requirements

A. A brief annual narrative report is due by November 15 following the end of the fiscal year, describing CSHCS successes, challenges and any technical assistance needs the LHD is requesting the State to address. Also, if your agency allocated any local MCH funds to CSHCS, briefly describe how those funds are used (e.g., CSHCS salaries, outreach materials, mailing costs, etc.)

B. Report the duplicated number of clients referred for diagnostic evaluations, the unduplicated number of CSHCS eligible clients assisted with CSHCS enrollment, and the unduplicated number of CSHCS clients assisted in the CSHCS renewal process.

Duplicated Number of Clients Referred for Diagnostic Evaluation is defined as: Number of individuals the local health department (LHD) referred for and/or assisted in obtaining a diagnostic evaluation during the fiscal year. Those eligible for this service must have symptoms and medical history indicating the possibility of having a CSHCS qualifying condition that cannot be determined from existing medical information. Individuals currently enrolled in a commercial Health Maintenance Organization (HMO), Medicaid Health Plan (MHP) or with other commercial insurance coverage must seek an evaluation by an appropriate physician subspecialist through their respective health insurer. A diagnostic may be issued for insured persons to cover the cost of the evaluation that is by policy not covered by the health insurance (e.g. co-pay, deductible).

Unduplicated Number of CSHCS Eligible Clients Assisted with CSHCS Enrollment is defined as: Number of CSHCS eligible clients the LHD assisted in the CSHCS enrollment process during the fiscal year. This assistance includes but is not limited to helping the family obtain necessary medical reports to determine clinical eligibility, completing the CSHCS Application for Services, completing the CSHCS financial assessment forms, etc. "Assisted" refers to help provided either over the telephone or in person with the client.

Unduplicated Number of CSHCS Clients Assisted in the CSHCS Renewal Process is defined as: Number of CSHCS enrollees the LHD assisted in the completion and/or submission of the documents required for MDCH to make a determination whether to continue/renew CSHCS coverage during the fiscal year. "Assisted" refers to help provided either over the telephone or in person with the client.

SECTION 8: CSHCS PROGRAM ELIGIBILITY

LHD procedures for Medical Eligibility and Diagnostic Referral included at the end of this section

8.1 Medical Eligibility

CSHCS covers over 2,500 medical diagnoses that are handicapping in nature and require care by a medical or surgical sub-specialist. A current list of covered diagnoses is maintained on the MDCH website and included in Appendix E.

Diagnosis alone does not guarantee medical eligibility for CSHCS. To be medically eligible, the individual must:

- **Have at least one of the CSHCS qualifying diagnoses.**
- **Be within the age limits of the program:**
  - **Under the age of 21; or**
  - **Age 21 and above with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia.**
  - **Meet the medical evaluation criteria during the required medical review period as determined by a** CSHCS **medical consultant regarding the level of severity, chronicity and need for treatment. (Refer to the Medical Renewal Period subsection of the Coverage Period Section of this chapter).**

The information needed from an appropriate sub-specialist to establish or renew CSHCS medical eligibility includes the following:

- Primary Diagnosis(es)
- Current problems (noting severity)
- Current treatment plan (including medications, services, equipment, anticipated hospitalization and follow-up care)

Type(s) of specialty care required

A CSHCS **medical consultant conducts the medical determination by reviewing the written report of a sub-specialist physician. The medical information may be provided** to CSHCS **in the form of a comprehensive letter, hospital consultation or summary, or the Medical Eligibility Report Form (MERF) (MSA-4114;** Appendix D**). Medical information is reviewed in the context of current standards of care, as interpreted by a** CSHCS **medical consultant. All of the criteria described below must be met for the individual to be considered medically eligible:**

- **Diagnosis: The individual must have a CSHCS qualifying diagnosis where his activity is or may become so restricted by disease or deformity as to reduce his normal capacity for education and self-support. Psychiatric, emotional and behavioral disorders, attention deficit disorder, developmental delay, mental retardation, autism, or other mental health diagnoses are not conditions covered by the CSHCS program.**
- **Severity of *Condition*: The severity criteria is met when it is determined by the** CSHCS **medical consultant that specialty medical care is needed to prevent, delay, or significantly reduce the risk of activity becoming so restricted by disease or deformity as to reduce the individual's normal capacity for education and self-support.**
- ***Chronicity of Condition*: A condition is considered to be chronic when it is determined to require specialty medical care for not less than 12 months.**
- ***Need for Treatment by a Physician Sub-specialist*: The condition must require the services of a medical and/or surgical sub-specialist at least annually, as opposed to being managed exclusively by a primary care physician.**

Medical information submitted for the purpose of renewing CSHCS **eligibility is generally considered current when it is no more than 12 months old. Initial determination of medical eligibility may require reports that are more current to document the individual's current medical status.** Medical information should be faxed to CSHCS Customer Support (see Appendix B for contact information).

Covered medical diagnostic categories include, but are not limited to:

- **Cardiovascular Disorders**
- **Certain chronic conditions peculiar to newborn infants**
- **Congenital anomalies**
- **Digestive Disorders**
- **Endocrine Disorders**
- **Genitourinary-Urinary Disorders**
- **Immune Disorders**
- **Late effects of injuries and poisonings**

- **Musculoskeletal Disorders**
- **Neoplastic Diseases**
- **Neurologic Disorders**
- **Oncologic and Hematologic Disorders**
- **Respiratory Disorders**
- **Special Senses (e.g., vision, hearing)**

CSHCS does not cover acute/specialty care that is not related to the CSHCS qualifying diagnosis. CSHCS also does not cover primary care, well-child visits, immunizations, or mental health care. Examples of diagnoses, conditions or procedures not covered include, but are not limited to:

- **Acne**
- **Allergies, without anaphylaxis**
- **Anorexia Nervosa**
- **Appendicitis**
- **Attention Deficit Disorder**
- **Autism**
- **Behavioral Problems**
- **Bronchitis (acute), croup**
- **Childhood Illnesses (measles, mumps, chicken pox, scarlet fever, etc.)**
- **Cosmetic Surgery**
- **Depression**
- **Developmental Delay**
- **Headache, migraines**
- **Hernia (inguinal or umbilical)**
- **In utero treatment**
- **Pneumonia**

- **Refractive Errors and Astigmatism**
- **Sinusitis**
- **Tonsillitis, strep throat**

8.2 Release of Information

When a client requests that a provider send medical information to CSHCS or another entity, the provider usually requires the client to sign a Release to Obtain Medical Information. Medical information is necessary to:

- Establish or renew medical eligibility for the CSHCS Program
- Obtain information about the client to assist with care coordination needs
- Assist the LHDs in understanding the client's case management needs.

When attempting to establish new medical eligibility for CSHCS, the Release to Obtain Medical Information form (MSA 0838; Appendix D) may be used. The person who is legally responsible for the client, or the client when responsible for self, can sign the release form for the provider's records. Individual providers may require that a different form be signed by the legally responsible party prior to releasing medical information.

When attempting to renew medical eligibility, CSHCS mails the Request for Medical Information form (see sample at the end of this section) to the client/family for the purpose of assisting in the renewal process. The request must be signed as indicated above and taken to the sub-specialist.

In certain situations, it may be necessary to transfer a client's medical information or other protected health information from one LHD to another (e.g., family moves to a different county, etc.). LHDs should consult with their agency's Privacy Officer for policies and procedures regarding the release or transfer of medical information.

The client, or legally responsible party has the right to limit the duration of the authorization to release medical information and may withdraw at any time, unless information has already been released according to the authorization.

8.3 Diagnostic Evaluations

CSHCS covers diagnostic evaluations for individuals when symptoms and history indicate the possibility of a CSHCS qualifying condition but the appropriate medical information cannot be obtained from their current provider(s). Diagnostic evaluations are to determine whether an individual meets the medical eligibility criteria for CSHCS, not for providing treatment. The local health department (LHD) assists in obtaining these diagnostic evaluations. Treatment is not a CSHCS benefit until a qualifying diagnosis is established and the individual has enrolled in the CSHCS Program. Individuals currently enrolled in a commercial Health Maintenance Organization (HMO), Medicaid Health Plan (MHP), or with other commercial insurance coverage must seek an evaluation by an appropriate physician sub-specialist through their respective health plan or health insurance carrier to provide medical documentation of a CSHCS qualifying diagnosis.

A "Referral and Authorization for CSHCS Diagnostic Evaluation" form (MSA-0650; Appendix D) must be completed for any individual in need of a diagnostic evaluation. When completing the MSA-0650, the section titled "Reason(s) for Referral or Follow-Up" should include the reason for the referral, listing of any tests that have already been done, and any pertinent questions the LHD would like addressed. It is strongly recommended that a LHD nurse review diagnostics before they are issued. A copy of the MSA-0650 needs to be sent to the CSHCS Central office.

The purpose of a diagnostic evaluation is to determine whether an individual meets the medical eligibility criteria for CSHCS. Diagnostic evaluations should only be authorized by the LHD when determination of CSHCS eligibility is needed and all other means of obtaining the information have been exhausted. Diagnostics are not appropriate for:

- evaluating conditions that are not covered by CSHCS,
- general monitoring purposes,
- obtaining treatment,
- saving families from the cost of co-pays or deductibles when a diagnostic evaluation is not warranted;
- avoiding enrollment in CSHCS because of a payment agreement.
- yearly check-ups in field clinics; or
- a visit to a Developmental Assessment Clinic (DAC).

If a child sees a specialist on a yearly basis for the same diagnosis and the family does not enroll, it is acceptable to discuss with the family their intent to enroll in CSHCS prior to authorizing the diagnostic. When it is clear that there is no intent to enroll, or if there is a repeated pattern of not following through with the enrollment process, the LHD may deny requests for a diagnostic evaluation. Requests for a new diagnosis are authorized according to the usual procedure.

Diagnostic evaluations may be covered for current CSHCS clients to determine if the client has additional diagnoses that are covered by the CSHCS program. Each new diagnosis should be established according to the same procedures as the original diagnosis. The preferred method for establishing eligible diagnoses is through the receipt of medical reports whenever possible. Diagnostic referral is performed if appropriate documentation is not available.

The initial diagnostic referral is generally made to the physician (pediatric specialist). Occasionally, further testing (e.g., laboratory, x-ray, etc.) is required to determine the diagnosis, or may be requested by the CSHCS medical consultants to determine medical eligibility. Additional facilities usually have separate billing agents (unless all are housed under one clinic) and each facility requires a diagnostic authorization to bill for services. Inpatient testing requires review prior to authorization at the local level.

If an individual has been evaluated and denied CSHCS medical eligibility in the past, the CSHCS medical consultant may approve a return diagnostic visit to determine and establish eligibility at a later date in the event that a condition has changed and meets medical eligibility criteria. The specialist's medical report and any other test results from the diagnostic evaluation should be sent to CSHCS for determination of medical eligibility. You may issue a diagnostic for a return visit if you have determined that no other payment source is available (Medicaid, private insurance, etc.) and no new medical reports have become available. In the event that the family has already enrolled in CSHCS prior to the return visit, the provider can be added to the authorized provider list for that date of the return visit only. The CSHCS medical consultants will need to approve an additional diagnosis in order for the specialist to be added for the entire eligibility year.

Diagnostic evaluations are usually performed in outpatient hospital-based specialty clinics. There are certain types of evaluations that may be appropriately authorized in a physician's office due to the unique diagnostic equipment requirements of a particular specialty (e.g. ophthalmology, otology, neurology and pediatric allergy). When the diagnostic evaluation has been completed, the clinic or physician sends a copy of the medical report to the CSHCS Division.

Diagnostic evaluations do not require a referral from a pediatric sub-specialist or physician. A CSHCS representative or LHD nurse can initiate diagnostic evaluations for:

- Individuals without current CSHCS coverage who are not enrolled in a commercial or Medicaid Health Plan;
- CSHCS-only clients;
- Clients who have commercial insurance in certain circumstances
- Non-U.S. citizens (even if family may not be eligible to enroll in CSHCS)

If the beneficiary has Medicaid Fee for Service (FFS), a diagnostic referral is not necessary. The LHD should contact the CSHCS regional nurse consultant (RNC) if the family encounters any difficulties in obtaining the appointment.

If the individual is enrolled in a Medicaid Health Plan (MHP), the MHP is responsible for the evaluation. If the MHP has declined the request to be seen by a pediatric specialist, the CSHCS Medical Consultant may speak with the MHPs on a case-by-case basis to discuss the need for appropriate referral for diagnostic or medical information. If the MHP refuses to authorize the diagnostic evaluation, the family should request the denial in writing and pursue the appeals process through the MHP and/or MDCH.

When an individual has other health insurance coverage, the rules of the other health insurance (provider network, prior approval, etc.) must be followed and the other health insurance must be billed prior to billing MDCH. A diagnostic may be issued for persons with other insurance coverage to reimburse for costs not covered by the other insurance carrier (e.g. co-pay, deductible, etc.) If the client has no other health insurance coverage, CSHCS will cover the cost of the diagnostic evaluation.

In the event that the other insurance or HMO refuses to allow the client access to the appropriate subspecialist, the client should file an appeal with the other insurance carrier or HMO.

CSHCS does not cover diagnostic evaluations as part of school based services. Any evaluations needed for educational purposes are to be covered by the Intermediate School District (ISD). If there is the potential that an individual will meet the medical eligibility criteria for CSHCS, you may issue a diagnostic.

It is not appropriate to issue a diagnostic if a child is receiving care at an out of state (OOS) facility and it becomes apparent that additional work-ups are indicated. OOS referrals are for specific services. Medical reports from the OOS physician should be submitted to update the status of the individual. The program can provide retroactive coverage for additional diagnoses or services if needed. The CSHCS medical consultants are equipped to handle these matters as expeditiously as necessary.

CSHCS contributes funds at the state level to support the Genetics Services Payment Program. Families are eligible for assistance when they have no other source of payment. This funding covers genetic counseling only and not the full diagnostic work-up. If there is the potential that an individual will meet the medical eligibility criteria for CSHCS, you may issue a diagnostic. The CSHCS medical consultants decide whether or not to add a geneticist to the child's eligibility for more than one DOS.

It is rare that you would need to issue a retroactive diagnostic evaluation. If a currently enrolled CSHCS client saw a specialist unrelated to his/her qualifying diagnosis, that provider can be added to the client's eligibility for that date of service only and you should not issue a retroactive diagnostic. If a currently enrolled CSHCS client saw a specialist unrelated to his/her qualifying diagnosis and was approved for an additional diagnosis, that provider can be added retroactively to the child's eligibility and you should not issue a retroactive diagnostic. Call your RNC before issuing a retroactive diagnostic.

CSHCS supports Early Hearing Detection and Intervention (EHDI) guidelines for screening by one month of age, diagnosis by three months of age, and intervention by six months of age. Some LHDs and/or Early On providers are equipped to perform hearing screenings for newborns who failed their initial screen. If this is not available in your area, it is appropriate to issue a diagnostic to the:

- audiologist for failed newborn screening cases;
- audiologist for children less than six months of age;
- otolaryngologist for children over six months of age.

8.4 Other Eligibility Considerations

8.4-A Citizenship Status

The individual, or parent of a minor, or legal guardian of the individual must be a citizen of the U.S., a non-citizen lawfully admitted for permanent residence, or a lawfully admitted migrant farm worker (i.e., temporary agricultural worker). Any individual born in the United States who meets all other program eligibility criteria is deemed eligible regardless of the citizenship status of the parents/legal guardian.

- **Non-citizens who have been granted admission to the U.S. for a temporary or specific period of time are not eligible for CSHCS coverage other than as specified below.**
- CSHCS **requires a statement of citizenship status from the family if the information is unclear from the application.**
- CSHCS **may request verification of citizenship or permanent resident status.**

There are some exceptions by U.S. Citizenship and Immigration Services (USCIS) that allow legal status for individuals with specific reasons for non-permanent entry in the U.S. who are recognized as potentially eligible for full Medicaid coverage (as opposed to Emergency Services Only coverage). CSHCS recognizes the same individuals for coverage when all other CSHCS qualifying criteria are met.

CSHCS sends the Citizenship Status check-off form (see sample at the end of this section) to all families whose information on the application indicates that the individual is not a U.S. citizen. The Visa class/type code can be found on the front of the Visa; the class/type code of either the parent/legal guardian or the child is acceptable. If the expiration date on the front of the Visa has passed and the term of the Visa has been extended, use the most current expiration date. A new expiration date may be stamped on the back of the Visa or the family may have additional paperwork with a new date.

It is not necessary to send copies of the Visa or other documentation with the Citizenship Status form unless the family chooses to do so. When conflicting information regarding citizenship status exists or remains unclear based on the information submitted on the form, CSHCS may request copies of the family's documentation to verify that the above criteria are met before CSHCS coverage can be issued.

Families who already have CSHCS coverage may be requested to provide documentation to CSHCS if information becomes available that their citizenship status may not meet eligibility criteria. CSHCS may end coverage if the submitted documentation does not support the citizenship status required for CSHCS eligibility.

8.4-B Residency

The individual, parent, legal guardian, or foster parent of the individual must be:

- **A Michigan resident(s); or**
- **Working or looking for a job in Michigan, and living in Michigan (including migrant status); or**
- **In Michigan with the clear intent to make Michigan their home.**

A Michigan resident who is temporarily absent from the state (e.g., out-of-state college attendance, member of a family stationed out-of-state for military service, or other extenuating circumstances allowed by MDCH) and agrees to return to Michigan at least annually for subspecialty medical treatment of the qualifying diagnosis(es) meets the criteria for residency.

CSHCS does not issue or maintain coverage when the individual/client is known to be out-of-state (except for the circumstances listed above) even if the parent, legal guardian or foster parent meets the criteria for residency.

8.4-C Long Term Care Facility

CSHCS does not issue or maintain coverage when the individual/client is known to reside in a long term care facility whose rate of payment includes medical care and treatment (e.g. nursing home, ICF/MR, inpatient psychiatric hospital, etc.). The individual/client can re-apply for CSHCS coverage or have CSHCS coverage reinstated when the living arrangement changes and all other eligibility criteria are met.

Citizenship Status

CITIZENSHIP STATUS

Client Name: _____ **Date of Birth:** _____ **County:** _____

You answered **"No"** to the U.S. citizenship question on the CSHCS application. Please complete and return this form. This form is used to check if the client's or your citizenship status meets CSHCS guidelines. Sometimes a child can be covered due to the parent/guardian's citizenship status.

Please check **ALL** boxes that describe the citizenship status of both persons below:

Person who needs CSHCS coverage:

☐ was born in the United States

☐ is a lawfully admitted migrant farm worker

☐ has Visa Type/Class: _____
Expiration Date: _____

☐ has a Permanent Resident card ("Green Card")
Expiration Date: _____

☐ Other (specify): _____

Parent/Legal Guardian of person who needs CSHCS coverage:

☐ is a U.S. citizen

☐ is a lawfully admitted **migrant farm** worker

☐ has Visa Type/Class: _____
Expiration Date: _____

☐ has a Permanent Resident card ("Green Card")
Expiration Date: _____

☐ Other (specify):_____

I certify under penalty of perjury, that the information on this form is true, complete and accurate to the best of my knowledge. I understand that any misrepresentation of the facts means that benefits may be taken away.

Signature (Legally Responsible Party):

_____ Date: _____

Print Name _____

Return completed, signed form to:

MDCH/CSHCS
PO Box 30734
Lansing MI 48909-8234

MDCH Use Only:
MA: _____ S/C: _____ Ctz: _____

Doc: _____

Revised 8/1/08

SECTION 9: CSHCS APPLICATION PROCESS

9.1 General Information

When the CSHCS **medical consultant determines the individual is medically eligible for CSHCS,** the Customer Support Section (CSS) **sends the individual an Application for Children's Special Health Care Services (MSA-0737;** Appendix D), the Income Review/Payment Agreement form (MSA-0738), the CSHCS Payment Agreement Guide (MSA-0738-B), and "Important Information About the CSHCS Application Process" (see end of this section). **The individual must complete the application** and the income review/payment agreement **and return to** CSHCS **to be considered for enrollment in the program. (See Appendix A for contact information). Applications submitted by the family cannot be processed until medical eligibility has been determined by** CSHCS.

Applications must be signed by the medically eligible individual (when legally responsible for self), or the person(s) who is legally responsible for the individual. Verification of legal guardianship may be required. Either parent can apply for CSHCS coverage for the individual regardless of shared custody.

Stepparents are not considered the legally responsible persons to sign the application unless the step-parent is in the legal process of adopting the child or is the child's court appointed guardian.

The application must be completed and submitted to CSHCS **as directed on the application form.** CSHCS **will notify the individual by mail if the application is incomplete and cannot be processed. The individual has 30 calendar days from the date of** the CSHCS **letter to submit the required information in order to preserve the initial coverage date. Failure to submit the required information within the required time frame may result in the coverage date being delayed.**

The medically eligible individual/parent/legal guardian can:

- Complete the application and income review independently
- Call or go to the CSHCS Office in the LHD for assistance in completing the forms

Call the CSHCS CSS for answers to questions related to completing the required forms

The individual must complete the application process in order to receive CSHCS benefits. Interviews are not required. A chronological summary of the application process is included at the end of this section.

If the applicant has other insurance coverage, include a copy of the insurance card (front and back) with the application.

9.2 Financial Determination

MDCH conducts an initial financial determination for new applicants/families and thereafter, annual financial determinations of all CSHCS clients/families, as required through the Michigan Public Health Code (Act No 368 of the Public Acts of 1978 – Part 58, Section 333.5823, .5825, .5841). Financial resources do not prevent a medically eligible individual from enrolling in the CSHCS program.

CSHCS reviews the CSHCS Income Review/Payment Agreement (MSA-0738) submitted by all* individuals. The review serves to:

- **Determine whether the individual/family income is sufficient to establish a payment agreement to pay toward the costs of the medical care received through CSHCS.**
- **Aid in identifying additional services or benefits for which the individual/family may be eligible.**

***Individuals determined medically eligible based on documentation submitted by their Medicaid Health Plan (MHP) are not required to submit the MSA-0738, as MHP enrollment is pre-verification of Medicaid coverage resulting in exemption from a payment agreement.**

9.3 Financial Determination Process

Individuals/families are exempt from a payment agreement if at least one of the following applies.

Individual to be covered:

- **Has full Medicaid coverage;**
- **Is enrolled in Women, Infants and Children (WIC);**
- **Is enrolled in MIChild;**
- **Is a ward of the county or state;**
- **Lives in a foster home or a private placement agency;**
- **Has a legal guardian;**
- **Is deceased (retroactive coverage).**

The MSA-0738 must be completed and submitted when applicable, either indicating the individual/family status is exempt from a payment agreement, or with the responsible party's income and family size as reported on the federal income tax return (Form 1040, 1040A, or 1040EZ) from the previous year.

During the time period January 1 through April 15 of any given year, an individual/family may or may not have filed a federal income tax return for the previous year:

- If the individual/family has filed a federal income tax return for the previous year, the information from that tax return is required to complete the MSA 0738.
- If the individual/family has not filed a federal income tax return from the previous year, CSHCS can accept information from the tax return for the year ending December 31, two years prior to the current year. This information can be accepted until April 15 of the current year. After the April 15th filing deadline, CSHCS requires the submission of information from the new federal income tax return. (See example below).
- If the individual/family has received an extension of the April 15 filing deadline, the MSA 0742 Financial Worksheet (Appendix D) must be completed with the tax information from the previous year. (See example).

Example: If the individual/family applies for CSHCS coverage in 2006, the information from the federal income tax return for the year 2005 is required. Between January 1, 2006 and April 15, 2006, if the individual/family has not yet filed a federal income tax return for the year 2005, CSHCS can accept the information from the 2004 federal income tax return. After April 15, 2006, the family must submit the 2005 federal income tax return. If the individual/family has been granted a filing extension for the year 2005, the completed MSA 0742 must be submitted with income and family size information relevant to the 2005 tax year.

If no federal income tax return is available, families may contact the LHD or the CSHCS Family Phone Line for further assistance (see Appendix A).

When an individual/family contacts the LHD for assistance and no federal income tax return is available, the LHD may use the MSA-0742 to determine the individual/family's income and payment agreement amount.

The following guidelines may be used to evaluate income:

- When the individual is a legally responsible adult (age 18 or over), or otherwise emancipated, include the income of the individual based on the federal income tax return from the previous year.
- When the individual is married and the most recent federal income tax return was filed jointly, include the income of both the individual and the spouse.
- When the individual is married and the most recent federal income tax return was filed separately, include only the income and family size reported on the individual's tax return.
- When the individual is a minor living with both birth/adoptive parents, and the most recent federal income tax return was filed jointly, include the income of both parents.
- When the individual is a minor living with both birth/adoptive parents, and the most recent federal income tax return was filed separately, include only the income and family size of the parent who claimed the minor child as a dependent.
- When the individual is a minor living with only one birth/adoptive parent, and that parent is applying for CSHCS coverage, include only the income of the applying parent.
- When the individual is a minor living with only one birth/adoptive parent, and the individual is not living with the parent applying for CSHCS coverage, include only the income of the applying parent.

- When the individual is a minor living with a step-parent, and the parent or step-parent actively questions the income review process, it is not required that the step-parent's income be included in the review. The LHD may use the MSA-0742 to recalculate the income and adjust the family size accordingly.

The LHD should instruct the individual/family to retain a copy of the MSA-0742, if applicable, as documentation for their records. Income verification may be requested.

9.4 Verification of Income

Individuals/families self declare income at the time of CSHCS application and renewal. Periodic reviews of randomly selected individual/family financial documentation are conducted. When the information submitted is problematic to completing the payment participation determination, or when an individual/family is randomly selected for verification of income, the federal income tax return may be requested. When the federal income tax return is not available, the individual/family may contact the LHD or the CSHCS Family Phone Line for further assistance. (Refer to the Directory Appendix for contact information).

When an individual/family contacts the LHD for assistance with income verification and no federal income tax return is available, the documentation used to complete the Financial Worksheet (MSA-0742; Appendix D), is needed to verify the individual/family's income.

9.5 Payment Agreement

CSHCS is required to determine an individual's/family's ability to pay toward the cost of the individual's care through the financial determination process. Those determined to be exempt from payment participation as described in subsection 9.3 are not required to pay toward the cost of care covered by CSHCS. The individual/family payment amount is established based on the income and family size reported by the responsible party on the federal income tax return from the previous year as indicated on the CSHCS Payment Agreement Guide (MSA-0738-B). The income is applied to a tiered scale to determine the amount of the payment agreement. The MSA-0738-B is updated at least annually.

Financial reviews occur and new payment agreements are re-determined annually and implemented (if still applicable) according to the client's CSHCS coverage period.

The MSA-0738 must be signed for CSHCS coverage to be implemented. The amount of the payment agreement is the total client/family financial obligation for one year, regardless of the number of family members with CSHCS coverage. The total amount of the financial obligation is due upon receipt of the payment agreement notification. The client/family is responsible for the total amount even if CSHCS coverage ends. Payments are non-refundable.

Families who have a change in financial circumstances should notify the LHD. When the LHD becomes aware of a change in circumstances that may affect the amount of the monthly payment agreement, the LHD representative completes the Income Review/ Payment Agreement Amendment form (MSA 0927; Appendix D), and submits to CSHCS. The LHD and the family receive a copy of the form showing the computation and approval of the new payment agreement amount. The agreement will be pro-rated up to 12 months back to the date of the event.

If the change in circumstances indicates that a payment agreement is no longer required, the client may be eligible for forgiveness of the unpaid balance. The current year payment agreement is terminated and outstanding balance forgiven within 30 days of notification to CSHCS of the change.

Unpaid balances may be forgiven and CSHCS coverage continued when the client has acquired Medicaid, WIC, or MIChild coverage.

When death of a client occurs during the client's CSHCS coverage period, a notice is sent to the family that the unpaid balance is forgiven. When the family notifies CSHCS that the payment agreement has been paid ahead in part or in full, MDCH pro-rates the monthly amount related to the coverage period for which the client is no longer covered due to death. The family is reimbursed the pro-rated amount. When death of a CSHCS client occurs and more than one family member has CSHCS coverage, the payment agreement remains intact.

A client/family may have no more than two outstanding years of incomplete or unpaid payment agreements. The client/family will not receive CSHCS coverage under a third year of a payment agreement until the oldest payment agreement obligation has been met.

When the client reaches the age of majority or otherwise becomes emancipated, outstanding payment agreements remain with the family who entered into the original agreements. When a change occurs in family finances after the client has reached age 18, the family is still liable for outstanding payment agreements and is not eligible for forgiveness of outstanding balances.

9.6 Chronological Summary of CSHCS Application Process

- Physician (preferably sub-specialist), hospital or Medicaid Health Plan (MHP) submits a medical report for determination of CSHCS eligibility to Customer Support Section (CSS). The report describes the client's potentially eligible diagnosis and current treatment plan. Family (especially those enrolled in MHP) may be unaware the information was sent to CSHCS.
- Family/client demographic information and Medicaid ID#, if available, are entered in CSHCS database along with the name of the provider who submitted the report.
- Medical report is forwarded to CSHCS medical consultant for eligibility decision.
- If the information is not complete for a determination, the case is pended. The decision and reason for the 'pend' are entered in CSHCS database. A 'pend' letter to the physician or family is produced requesting more specific information. Copies of the letter and medical report are sent to the LHD.

- If the information results in a denial of eligibility, the decision and reason for the denial are entered in CSHCS database. A denial letter to the family is produced. Copies of the denial letter and medical report are sent to the LHD (see Appendix L for denial codes).
- If the client is eligible for CSHCS, the decision and eligible diagnosis code(s) are entered in the CSHCS database. An "Invitation" letter to the family is produced. Copies of the letter and medical report are forwarded to the LHD. CSS may receive new medical information during the application process resulting in the client being eligible for additional diagnoses. Copies of the reports with the eligibility decision are sent to the LHD.
- CSS sends a package of information inviting the family to enroll the medically eligible client into CSHCS. Package includes:
  - Invitation to join letter
  - *For people who need a language other than English* flyer
  - *Children's Special Health Care Services (CSHCS) Application* (MSA-0737)
  - *Important Information* flyer
  - *Income Review/Payment Agreement* (MSA-0738)
  - *Payment Agreement Guide* (MSA 0738-B)
  - *Children's Special Health Care Services* brochure
  - *Authorization to Disclose Protected Health Information* (DCH-1183)
  - Return envelope
- Family has option to complete and return the application, which includes the income review/payment agreement form; request phone or in person assistance to complete the application; or decline application.
  - If family requests phone assistance, a Family Phone Line operator assists or transfers the call to the CSS analyst.
  - If family requests face-to-face assistance, Family Phone Line operator transfers the call to the LHD
  - If family contacts the LHD directly, assistance in completing the application forms is provided by phone or in person, per family's preference.

- If the family does not respond to the package within 30 days:
  - CSS requests the LHD's assistance to contact family and document response (Application Follow-Up Report).
  - If family declines application, LHD notes reason and advises CSS.
  - If family is interested in joining CSHCS, LHD offers family the options for completing the application (i.e., with or without assistance).
  - If LHD is unable to locate family, LHD notes status.
- The date CSS receives the completed application is entered on CSHCS database. A client ID number, if needed, is obtained from the Medicaid eligibility system. The ID number and any demographic updates are entered into the CSHCS database.
- The application is forwarded to the analyst assigned to the county/alpha area. The analyst reviews the application information for completeness.
- If the information is not complete, the analyst contacts the family for missing information.
- If the information is complete, the remaining family/client information, coverage start and end dates, authorized providers, and payment agreement details are entered onto the CSHCS database.
- If more than one sibling in a family has CSHCS coverage:
  - the coverage dates are adjusted to be the same for the family's convenience; and
  - the amount of the payment agreement is whatever it would be for one child, regardless of the number of children covered.
- Copies of the other insurance card and insurance form are forwarded to the Revenue and Reimbursement Division to verify insurance coverage and enter insurance information in CHAMPS.
- Once CSHCS coverage has been issued, CSS sends a copy of the application to the LHD. The MDCH system generates a mihealth card to the client and a Client Eligibility Notice (CEN) to the family listing the client's ID number, authorized providers and CSHCS coverage start and end dates. The CEN is sent to the LHD by CSS.

- CSS sends a welcome packet to the family that includes:
  - Welcome letter
  - *Family Support Network of Michigan* brochure
  - *Children with Special Needs Fund* brochure
  - *Using Other Health Care Insurance with Children's Special Health Care Services* brochure
  - *Children's Special Health Care Services Insurance Premium Payment Benefit* brochure
  - *Frequently Asked Questions about CSHCS Coverage* brochure
  - *Being Prepared for an Emergency* booklet
- LHD is required to contact family to introduce LHD role as a local resource for information and assistance in navigating CSHCS and community service systems. (See templates for *Welcome to CSHCS* letter and *Important Information About Your CSHCS Coverage* flyer at the end of this section).
- LHD offers family the opportunity to receive additional information about the CSHCS program and other community resources. Accepting the offer for additional information and assistance is optional for the family. When requested, additional information and assistance must be available and provided in a manner that is most convenient to the family through the mail, by telephone or in person (at home, hospital, LHD, another site).
  - If the family chooses to receive the additional information/assistance, LHD partners with the family to share information, identify needs, and document routine LHD and/or family follow-up planned or case management/care coordination activities needed.
  - The LHD may use the *CSHCS Service Needs Summary Record* (MSA-0741; Appendix D) to document information shared, referrals made and action/follow-up planned.

If family does not desire additional information, LHD will note status.

9.7 Exceptional Circumstances Payment Agreement Work Sheet:

Guidance to Local CSHCS Regarding
Exceptional Payment Agreement Circumstances

How to Determine Family Size/Exemptions

For step-parent families, if tax forms were filed jointly, the family may wish to deduct the step-parent income through use of the Financial Worksheet. When this occurs, count as exemptions only those individuals who received more than 50% of financial support in the previous year, from the responsible party whose income is being considered for a possible payment agreement.

If a family had not submitted tax forms the previous year, count as exemptions only those individuals who received more than 50% of financial support from the responsible party/parties.

If a family had submitted tax forms the previous year, but that income is no longer relevant because of drastic employment change, use the Financial Worksheet to determine income, but use the exemptions on the previous tax form to determine family size.

When to use the new Financial Worksheet

The Financial Worksheet should be used including but not limited to the following situations:

1. A drastic change in family income since previous tax forms were submitted (i.e., loss of job, change in job-lower wages.)
2. No Federal Income tax forms from the previous year
3. When family submitted a joint tax form and family wants to deduct the step-parent income.

Do not include as income unusual or rare income fluctuation such as one time capital gains, over-time (non-recurring), and other non-regular occurrence income.

What to do when the Family Size has Changed since the Previous Year's Income Tax Return

If an adoption or birth has occurred between the time that the taxes were filed and the CSHCS application is being completed, instruct the family to add the new family member(s) to the number of exemptions included on the previous tax form and enter it on line #8 of the Income Review/Payment Agreement form.

Call your Customer Support Section Analyst if you have questions

12/1/05

WELCOME TO CSHCS LETTER – TEMPLATE

Reproduce on LHD Letterhead with
Local CSHCS Office address
Local CSHCS Office phone

Date

Responsible Party Name
Responsible Party Address
Responsible Party City

RE: Client Name

Dear

Thank you for completing an application for Children's Special Health Care Services (CSHCS). Your CSHCS Eligibility Notice lists the coverage start and end dates. If you have questions or need to make changes, please call us. As your local CSHCS office, we are available to give you program information and assistance, guide you through service planning, and identify other resources you may need. **Our office hours are**.

Enclosed is important information about CSHCS. We will contact you soon to offer you more information about CSHCS and how to use its services. If you want, we also can share information about other services in your community.

You may reach our office via the toll-free CSHCS Family Phone Line at 1-800-359-3722. Ask the operator to transfer you to **my phone number: (____) _____-_____**.

You also may phone that number if you'd like to talk with other family members of children with special needs. Trained, volunteer parents across the state are part of the Family Support Network of Michigan (FSN). You may be matched one-to-one with a support parent. Or, you can check whether an FSN chapter meets near you. FSN is the parent-to-parent arm of the Parent Participation Program, which is a section of CSHCS.

Welcome to the Children's Special Health Care Services Program. We look forward to serving you and your family.

Sincerely,

Name, Title
Health Department

Enclosure

Michigan Department of Community Health
Children's Special Health Care Services (CSHCS)

Important Information about Your CSHCS Coverage

(Welcome letter enclosure 02/07)

Covered Services:

The specialists, hospitals and services covered depend on a CSHCS member's *qualifying* d*iagnosis*. To check what we cover, read your CSHCS Eligibility Notice. For details, call the CSHCS office in your local health department. Or call our CSHCS Family Phone Line at 1-800-359-3722.

Your Eligibility Notice also lists your coverage's start and end dates. In some situations, past services related to your eligible diagnosis may be covered. But even if past services are covered, the provider may not be willing to accept CSHCS payment.

Primary Care:

CSHCS does not cover primary care. That means we don't cover common colds or childhood illnesses. We only pay for treatment related to the member's CSHCS-*qualifying* diagnosis.

To find primary care, talk with the CSHCS office in your local health department. If your income qualifies, your child may get primary care through Medicaid or MIChild. Private health insurance usually includes primary care.

Urgent Needs:

If you urgently need coordination of surgery or other services, call 1-800-359-3722.

Prior Approval (PA):

If you have other insurance, you must get approval from that carrier and CSHCS for many services. If you need medical equipment or supplies, check with your medical supplier. Even when the provider is listed on your Eligibility Notice, some services require CSHCS approval before you get the service. You *always* need prior approval if you want to receive care out of state.

Prior approval for some items takes several steps. For a wheelchair, for example, you first need a prescription from your specialist. Then your wheelchair provider sends the prescription to CSHCS for approval.

Changing Providers:

If your Eligibility Notice does not list all the providers who take care of the special needs, please call the CSHCS office at your local health department. You may add a provider or take one off anytime. To add a provider, we need:

- the doctor's name.
- the address where services are provided.
- what the doctor is treating.
- dates of treatment.

After each change, we will mail a new Eligibility Notice to you.

Transportation:

If you need help with travel or lodging costs while your child is in a hospital away from home, check with the CSHCS office in your local health department to see if you qualify. We also may be able to reimburse your costs for transportation to medical appointments.

Important CSHCS Information

page two

Take Your Eligibility Notice and mihealth Card Every Time:

Your CSHCS Eligibility Notice and mihealth card work like a health insurance card. You must show them before you receive service from a CSHCS provider.

That's important. If you do not show your Eligibility Notice until after a provider serves you, the provider does not have to accept CSHCS coverage. When CSHCS coverage is not accepted, your family must pay the bill. Pharmacies, medical equipment/supply companies and hearing aid providers do not need to be listed on the Eligibility Notice.

Billing:

If you have other insurance, please note that it needs to be billed first. By law, CSHCS is the "payer of last resort."

For answers to any CSHCS question,
call our Family Phone Line:
1-800-359-3722

We can transfer you to

your local health department

or any section of CSHCS.

The call is free.

9.8 How to Reimburse Children's Special Health Care Services

Clients/families are not obligated to reimburse the CSHCS program under usual circumstances. If a client/family does wish to reimburse the program, the LHD may instruct the client family to send a written request to CSHCS Customer Support Section (see Appendix B for contact information).

The request should include the client's name and recipient ID number. The client/family will receive a response back from CSHCS that includes the client's medical care expenditures report and instructions on how to reimburse the program.

SECTION 10: CSHCS COVERAGE PERIODS

10.1 Effective Date

Once the application is complete, the effective date of CSHCS coverage is dependent upon the individual's other health care coverage. When the individual has:

- **Commercial insurance coverage or no other health care coverage - The CSHCS effective date is the day the application was signed when submitted* within 30 days of the signature. Applications submitted later than 30 days of the signature are made effective on the submission date*.**
- **Medicaid, Transitional Medical Assistance (TMA), TMA-Plus, ABW I, or MIChild - The CSHCS effective date is prospective to the first day of the first available month after the CSHCS application has been processed, according to the mihealth card cut-off processing time frames. This could result in the CSHCS effective date for coverage being as early as two weeks or as late as six weeks from the time of processing.**

When information is missing, the individual has 30 days from the date of the letter sent from MDCH requesting the missing information to submit* the information in order to preserve the initial effective date of coverage. Failure to submit the required information within the timeframe indicated results in the effective date of coverage being delayed until the date that all necessary information has been submitted to DCH. Individuals/families are required to provide complete and accurate information at the time of application and as circumstances change. At a minimum, changes in address and insurance must be reported as they occur.

***Submission date is considered the date the document is received by CSHCS.**

10.2 Coverage Period

Upon completion of the application or renewal CSHCS coverage is typically issued in 12-month increments.

Clients who have both CSHCS and Medicaid coverage are excluded from enrollment into a Medicaid Health Plan (MHP).

- When a client becomes enrolled in CSHCS and is already enrolled in a MHP, the client is disenrolled from the MHP and returned to Medicaid Fee-for-Service (FFS)
- Upon review, MDCH may initiate a retroactive disenrollment from the MHP effective the first day of the month in which CSHCS medical eligibility was determined. Retroactive disenrollment from a MHP does not change the CSHCS coverage begin date.

10.3 Certificate of Medical Coverage

Certificates of Medical coverage are included as part of HIPAA. The certificate requires a new insurance carrier to accept an individual with a pre-existing condition without a waiting period or exclusion from coverage for that condition. A Certificate of Medical coverage may be beneficial to families who have had a change of insurance carriers due to new employment, or the current employer's decision to change to another insurance carrier.

A Certificate of Medical Coverage will be issued to any family who requests one. A Certificate of Medical Coverage may be needed when:

- CSHCS coverage ends and the client/family acquires new private insurance coverage
- CSHCS coverage remains but the client/family has a change in the private insurance coverage

LHDs can submit the request for a Certificate of Medical Coverage to the CSHCS insurance specialist (see Appendix A). The request must contain the client name, client ID number, client Social Security Number, and current client address.

10.4 Retroactive Coverage

In some instances, the client's coverage may be retroactive up to three months when requested by the family. This may occur if, during that time:

- **All CSHCS medical and non-medical eligibility requirements were met; and**
- **Medical services related to the qualifying diagnosis(es) were rendered and remain unpaid with no other responsible payer (e.g., Medicaid, private insurance, etc.).**

Coverage does not guarantee that providers of services already rendered will accept CSHCS payment. CSHCS does not reimburse families directly for payments made to providers.

10.5 Partial Month Coverage

If a client enters or leaves a facility that is not a covered facility (e.g., nursing home, or intermediate care facility) during a month of eligibility, the client remains a CSHCS client for the remainder of that month. However, services provided to the client while in the facility are not covered (i.e., reimbursable) by CSHCS, as these facilities are responsible for providing the medical care.

10.6 Incarceration or Juvenile Detention Facility

When a CSHCS client resides in an incarcerating facility or juvenile detention facility, the client remains enrolled in CSHCS. For CSHCS clients who also have Medicaid coverage, CSHCS follows Medicaid policy regarding coverage of persons who are inmates in an incarcerating facility (see the Beneficiary Eligibility Section of the Medicaid Provider Manual). For clients who only have CSHCS coverage, the client remains CSHCS enrolled but is required to access care through the authorized providers on the client's file for services to be reimbursed.

10.7 Service Delivery (FFS)

The Fee-for-Service (FFS) system is the method of reimbursement for service delivery for CSHCS clients. CSHCS coverage is limited to specialty health care services for the client's CSHCS qualifying diagnosis(es). Physicians, dentists, hospitals, and selected ancillary providers must be authorized on the CSHCS client's file. Providers must obtain authorization for some services (e.g. medical equipment and supplies) as required per Medicaid policy.

The LHD should be the point of contact any time a client/family desires a change to the authorized provider list. The LHD notifies CSHCS of the requested change by e-mailing CSHCS (see Appendix A) or through the NOA (MSA 0730; Appendix D). The information submitted must include the provider name, address, phone number and specialty, provider ID number and provider type (if known). Requests to add or change providers are forwarded to the analyst for appropriate action.

Clients with additional coverage (e.g., Medicaid, MIChild, private insurance, etc.) continue to receive primary care, well child visits, immunizations, etc. through that source of coverage.

10.8 Renewal of Coverage

The client's coverage may be renewed as needed if all eligibility criteria continue to be met and the family completes the renewal process. Medical review reports are required according to the time frames established based on the primary diagnosis for the client. An annual financial review is also required. If all of the criteria continue to be met for CSHCS coverage, a new coverage period is typically issued in 12-month increments.

Renewal information may be submitted after the CSHCS coverage period has already ended.

- When the information required for renewal of CSHCS coverage is submitted within sixty (60) days of the date CSHCS coverage ended or lapsed, and the client remains eligible for CSHCS, the CSHCS coverage is renewed retroactively with no break in the CSHCS coverage period.
- When the information required for renewal of CSHCS coverage is submitted more than sixty (60) days but less than one year after the date CSHCS coverage ended or lapsed, and the client remains eligible for CSHCS, the CSHCS coverage is renewed according to the following guidelines:
  - Commercial insurance coverage or no other health care coverage - The CSHCS renewal effective date is the day the renewal information was received
  - Medicaid, Transitional Medicaid Assistance (TMA), TMA-Plus, ABW I, or MIChild - The CSHCS renewal effective date is prospective to the first day of the first available month after the renewal information has been received, according to the mihealth card cut-off processing time frames.

  When the information required for renewal of CSHCS coverage is submitted more than one year after the date CSHCS coverage ended, the case is considered new and the family must re-apply for CSHCS coverage.

The LHDs assist with providing updated information to CSHCS during the annual renewal period, or any time a change occurs during the client's eligibility period. Updates may be submitted on the CSHCS Annual Information Update form (see sample at the end of this section) or the Notice of Action (NOA) to/from Local Health Departments (MSA 0730; Appendix D). The LHDs may also assist families in obtaining renewal medical information and in completing the financial assessment if required for renewal of CSHCS coverage.

10.9 Medical Renewal Period

The CSHCS medical renewal period is established at one year, two years, three years, or five years, depending upon the CSHCS primary diagnosis (see Appendix E)**.**

Medical reports for renewal of coverage (refer to the Renewal of Coverage subsection) are required consistent with the time frames indicated by the CSHCS medical renewal period.

When the client has more than one CSHCS qualifying diagnosis, the diagnosis determined by MDCH to be primary is used to determine the time interval for required medical information to be submitted for all covered diagnoses. This results in a single periodic medical review process per client. When the medical review process results in the elimination of one of the qualifying diagnoses, while maintaining another diagnosis, the new coverage period is based on the time frame associated with the new primary diagnosis.

Example: **Client has three diagnoses, each related to a different medical review period. All new medical information is required according to the medical renewal time period of the primary diagnosis.**

A change of primary diagnosis during the medical renewal period does not change the time period unless and until the current medical renewal period has been completed and a new one is established.

10.10 CSHCS Annual Review Process

The Public Health Code and CSHCS program policy mandate the periodic review of medical reports and financial assessment to determine ongoing program eligibility and level of financial participation. The CSHCS Annual Review Process documents continued medical eligibility for the CSHCS program, re-establishes client/family level of financial participation for program services, and provides updated client information to the CSHCS program.

The LHD assists CSHCS in conducting the annual review of each client prior to the end date of the client's current CSHCS coverage period. The information required for the annual review may be different for each client depending on the circumstances. The Annual Review Process may consist of any or all of the following:

- Annual Update: **Clients are requested to provide updated information during the annual renewal of the coverage period regarding current providers, address, other insurance, etc.**

Annual Financial Review: **Clients/families are required to provide updated financial information during the annual renewal of the coverage period to determine financial participation with the CSHCS Program. Those with Medicaid, MIChild or WIC are determined complete in the annual financial review each year those circumstances remain true.** Existing MDCH program eligibility records are used in lieu of the Financial Assessment form whenever possible.

10.10-A Chronological Description of the CSHCS Annual Review Process

5th Month Before CSHCS Coverage Ends

- CSHCS system checks for Medicaid, WIC, or MIChild eligibility. If any of these conditions exist on the date of the match, a new Financial Assessment form is not required for renewal of coverage.

4th Month Before CSHCS Coverage Ends

- CSHCS system generates a report to identify clients who are due for medical eligibility review, and determines "related" diagnoses by entering "R" on the CSHCS Online system.

3rd Month Before CSHCS Coverage Ends:

- CSHCS system generates a report to advise each LHD of all clients whose CSHCS coverage ends in three months.
- The LHD contacts every family by mail or telephone to obtain updated client information (e.g. address, insurance, providers, care needs, etc.). A template for an Annual Update Information form is provided at the end of this section. Updates may be submitted on the NOA (MSA-0730; Appendix D) or by e-mail for CSHCS (see Appendix A)
- If a copy of an annual update form is used to report changes, the LHD must highlight the areas of change before submitting to CSHCS.
- LHDs should not enter insurance information or send copies of insurance cards unless the information has changed. See Other Insurance Section for process and form to report a change in other insurance coverage.

- CSHCS sends a packet to the client/family *only if* income review and/or medical reports are needed. The packet may include any or all of the following as needed:
  - Release to Obtain Medical Information form created for each marked diagnosis that requires review
  - Income Review/Payment Agreement (MSA-0738; Appendix D) and current CSHCS Payment Agreement Guide (MSA-0738-B; Appendix D)
  - A return envelope (*only if income review needed)*

Month Before CSHCS Coverage Ends:

- LHD receives Renewal Follow-up Report listing clients for whom CSHCS still needs medical and/or financial information. LHDs follow up with each client or family to obtain the needed information

Month CSHCS Coverage Ends:

- CSHCS system creates a new coverage period for clients whose income review status is "complete" and whose medical eligibility status is "eligible" for at least one CSHCS qualifying diagnosis. Coverage period is typically 12 months. If a client is aging out of the CSHCS program, client coverage will only extend through the day before the client's 21st birthday
- CSHCS system generates a Beneficiaries Not Renewed report for the LHD. The report contains the names of clients whose CSHCS coverage ends at the end of the month and the reason(s) a new coverage period was not created. If CSHCS receives the required information within 60 days of the CSHCS coverage end date, CSHCS coverage is renewed retroactively to the coverage end date.
- CSHCS sends a Notice of Action (Close Out/Due Process) letter to the client whose CSHCS coverage expires at the end of the month and for whom a new coverage period was not created. The letter states the reason(s) CSHCS coverage was not renewed and provides due process (appeal) information.
- CSHCS sends a Notice of Action (Diagnosis Close Out/Due Process) letter (see sample end of this section) to the client whose CSHCS coverage was renewed, but for whom one or more CSHCS qualifying diagnoses were not renewed.

All coverage periods end on the last day of a month, or the client's 21st birthday if the client does not have a qualifying diagnosis that is covered beyond age 21.

10.11 Termination of Coverage

CSHCS coverage may be terminated before the current eligibility period has ended. Reasons for termination of coverage include, but are not limited to, the following:

- Family request
- Family moved out of state and does not meet any of the required circumstances to maintain coverage
- Client no longer meets medical eligibility criteria
- Medical information or financial information not submitted for renewal of coverage
- Two outstanding payment agreements
- Client turned 21 years and does not have a CSHCS diagnosis that is covered beyond age 21
- Client resides in a long term care facility (nursing home, psychiatric hospital, ICF/MR, etc.)
- Client died

When CSHCS coverage is terminated (except for cases where the client turned 21), the client receives a Notice of Action letter (also referred to as a Close Out/Due Process letter) from CSHCS stating the date CSHCS coverage ends, the reason for termination of coverage, and informs the client of the right to appeal the decision. An example of the Notice of Action (also called Close Out/Due Process) letter is included at the back of this section.

CSHCS clients who age out of the program (reached the age of 21 years) do not receive a Notice of Action (Close Out/Due Process) letter when CSHCS coverage ends. They receive a letter stating that CSHCS coverage is ending and the client should prepare for the transition.

Children's Special Health Care Services Division
ANNUAL INFORMATION UPDATE FORM

SAMPLE

Beneficiary Name: _____ID#:_____

We need your help to update your Children's Special Health Care Services (CSHCS) information. **Please complete this form and mail it, <u>or call</u>, to tell us of any changes over the last 12 months**. When you call, please have this form with you. Our phone number is .
NOTE: If CSHCS needs additional information about your eligibility, you will receive a mailing from the Lansing CSHCS main office.

Current Address: ☐ Address ☐ County	
Phone Numbers for Responsible Party: ☐ Name ☐ Home phone #:( ) ☐ Message phone #:( )	☐ Work phone #:( ) ☐ E-mail address:
Other Insurance (we must have a copy of the front and back of your new insurance card) ☐ Insurance Name ☐ Policy Number	☐ **Any Change in health or care needs**

Provider changes to current Client Eligibility Letter

Provider Name & Address	Specialty	Add	Remove

Signature_____**Date**_____

mail form to:

SECTION 11: PAPER VERIFICATION OF CSHCS ENROLLMENT

The provider must verify eligibility using the CHAMPS eligibility inquiry. Any clearing house vendor the provider chooses to use can receive eligibility data from CHAMPS by enrolling in CHAMPS as a billing agent. Providers must then associate themselves with the clearing house vendor as the billing agent through the CHAMPS Provider Enrollment subsystem.

11.1 The mihealth Card

The **mihealth** card is a plastic identification card issued once to each client. The front of the card contains the client's name and ID number. When a client becomes enrolled in CSHCS, a **mihealth** card is issued. The **mihealth** card does not contain eligibility information and does not guarantee eligibility until verified using the CHAMPS eligibility inquiry. The provider can access a client's eligibility information using CHAMPS eligibility inquiry by entering the ID number or other client information.

If the client has lost his **mihealth** card, a replacement card may be issued by contacting the Beneficiary Help Line. See Appendix B for contact information.

11.2 Client Eligibility Notice (CEN)

The CEN is a paper document that is automatically generated and mailed to CSHCS clients each time a change occurs in CSHCS eligibility or provider information. The information that appears on the CEN can be used to verify CSHCS eligibility using the CHAMPS eligibility inquiry. Fields identified with * are no longer used.

The following information appears on the CEN specifically as indicated below:

- Responsible Party name and address
- Client name
- Date of birth
- Sex
- Eligibility dates
- Region and County
- Other Insurance information*
- Client ID number
- Listing of CSHCS authorized hospitals, physicians, and dentists (not all provider types are required to appear on the authorized provider list)
- CSHCS qualifying diagnosis the provider is authorized to treat

- Provider type and specialty
- Dates of provider's authorization period

Clients may receive multiple CENs. Clients are encouraged to review each CEN to assure that the provider information listed on the CEN is correct (e.g., no error made in end dating provider).

The mihealth card

http://www.michigan.gov/mdch/0,1607,7-132-2943_4853-72891--,00.html

SECTION 12: CSHCS MEDICAL SERVICES COVERAGE

Effective July 1, 2009, Executive Order 2009-22 reduced the Dental, Hearing, Vision, Chiropractic, and Podiatry benefits for adults age 21 and over. CSHCS clients are included in the benefit reduction. Refer to the specific chapters of the Medicaid Provider Manual for details.

CSHCS covers services that are medically necessary, related to the client's qualifying diagnosis(es), and ordered by the client's CSHCS authorized specialist(s) or sub-specialist(s). Services are covered and reimbursed according to Medicaid policy unless otherwise stated in this chapter. Refer to the specific chapter of the Medicaid Provider Manual for current detailed information regarding coverage and prior authorization requirements. (See Appendix B for prior authorization contact information).

NOTE: When a CSHCS enrollee is also eligible for Medicaid and needs a service that is covered by both programs, the Medicaid coverage, benefits and rules take precedence over CSHCS. Any additional benefits available to the individual through CSHCS coverage are allowed and conducted according to CSHCS policy.

The primary CSHCS benefits may include:

- **Ambulance (emergency only)**
- **Care Coordination**
- **Case Management**
- **Dental**
- **Dietary Formulas (limited)**
- **Durable Medical Equipment (DME)**
- **Emergency Department (ED)**
- **Hearing and Hearing Aids**
- **Home Health (intermittent visits)**
- **Hospice**
- **Hospital at approved sites (Inpatient/Outpatient)**
- **Laboratory Tests**
- **Medical Supplies**
- **Monitoring Devices (Non-routine)**
- **Office Visits to CSHCS Authorized Physicians**
- **Orthopedic Shoes**
- **Orthotics and Prosthetics**

- **Parenteral Nutrition**
- **Pharmacy**
- **Physical/Occupational/Speech Therapy Radiological Procedures**
- **Respite**
- **Transplants and Implants**
- **Vision**

Private Duty Nursing (PDN) may be available for CSHCS clients who also have Medicaid coverage. Questions regarding the possibility of a CSHCS client becoming Medicaid eligible through TEFRA should be directed to the CSHCS insurance specialist (see Appendix A).

12.1 Dental Benefits

General and specialty dental services are covered when related to the CSHCS qualifying diagnosis. Some dental services require prior authorization. See the Dental Chapter of the Medicaid Provider Manual for coverage and prior authorization requirements.

12.1-A General Dental Benefits

General dentistry refers to diagnostic, preventive, restorative and oral surgery procedures. CSHCS may determine a client eligible for certain general dentistry services when the CSHCS qualifying diagnosis is related to conditions eligible for this coverage as identified below:

- **Chemotherapy or radiation which results in significant dental side effects**
- **Cleft lip/ palate/ facial anomaly**
- **Convulsive disorders with gum hypertrophy**
- **Cystic Fibrosis**
- **Dental care that requires general anesthesia in an inpatient or outpatient hospital facility for those with certain CSHCS diagnoses**
- **Hemophilia and/or other hereditary coagulation disorders**
- **Pre and post-transplant**

12.1-B Specialty Dental Benefits

Specialty dentistry is limited to specific CSHCS qualifying diagnoses and refers to services routinely performed by dental specialists. Examples include: orthodontia, endodontia, prosthodontia, oral surgery and orthognathic surgery. CSHCS diagnoses covered for specialty dental services include:

- **Amelogenesis imperfecta, Dentinogenesis imperfecta**
- **Anodontia which has significant effect of function**

- **Cleft palate/cleft lip**
- **Ectodermal dysplasia or epidermolysis bullosa with significant tooth involvement**
- **Juvenile periodontosis**
- **Juvenile rheumatoid arthritis and related connective tissue disorders with jaw dysfunction secondary to temporomandibular joint arthritic involvement**
- **Post-operative care related to neoplastic jaw disease**
- **Severe malocclusion requiring orthognathic surgery**
- **Severe maxillofacial or craniofacial anomalies that require surgical intervention**
- **Traumatic injuries to the dental arches**

To request approval as a CSHCS provider, dentists must contact MDCH (See Appendix B) to initiate the process of enrolling as a Medicaid provider. If the dentist is already enrolled as a Medicaid provider, the dentist or family can contact the LHD to be authorized for a specific client.

12.2 Pharmacy Contractor (Magellan Medicaid Administration, Inc.)

MDCH employs a contractor to serve as the MDCH Pharmacy Benefits Manager (PBM). CSHCS clients may obtain prescription drugs from any pharmacy enrolled with the contractor. The contractor is responsible for processing prior authorization requests for prescription drugs; denials of such requests are subsequently reviewed by a CSHCS medical consultant. Other contractor responsibilities include enrollment of pharmacies desiring to participate in the program, claims reimbursement, resolution of billing issues, maintaining the Michigan Pharmaceutical Product List (MPPL) and the Preferred Drug List (PDL), and reimbursement of mandatory mail order pharmacy co-pays (refer to the Private Insurance Mail Order Pharmacy COB Contractor section).. Pharmacies may call the PBM with questions or concerns; clients may call the PBM Beneficiary Helpline. See Appendix B for contact information.

12.3 Diaper and Incontinence Supplies Contractor (J & B Medical)

As required by Public Act 131 of 2009, for dates of service on or after December 1, 2009, selected incontinence supplies are only available to CSHCS clients who also have Medicaid coverage. Refer to the DME Chapter of the Medicaid Provider Manual for a complete list of incontinence supplies and coverage information.

CSHCS clients who require catheter supplies related to the CSHCS qualifying diagnosis must obtain these items through the MDCH contractor. The contractor conducts a nursing assessment on each new client to determine the specific product and appropriate quantity that will best meet the client's needs. The contractor is responsible for shipping the monthly supply of product to the client's home. See Appendix B for contact information.

12.4 Vision Contractor (Classic Optical)

MDCH employs a contractor to serve as the sole source provider for frames and lenses. CSHCS clients who have a qualifying diagnosis which includes coverage for glasses must obtain these services through the contractor. See Appendix B for contact information. Local optical companies or optometrists may agree to complete the necessary forms for ordering frames and lenses on behalf of the client. The optical company or optometrist is paid a dispensing fee for providing this service.

Optical companies (provider type 86) and optometrists (provider type 94) must be added to the client's authorized provider list before billing MDCH for the dispensing fee.

12.5 Children's Multidisciplinary Specialty (CMS) Clinics

Children's Multidisciplinary Specialty (CMS) Clinic services are covered for Children's Special Health Care Services (CSHCS) clients who have specific existing medical conditions. CMS Clinic services are reserved for those clients whose medical conditions are of a severe and chronic or disabling nature and require complex coordinated assessment and management.

CMS Clinics provide a coordinated, interdisciplinary approach to the management of specified complex medical diagnoses. Services are provided by a team of pediatric specialty physicians and a complement of other appropriate health professionals (listing is at the end of this section).

The CMS Clinics provide:

- opportunity for organized communication among specialty providers to ensure efficient coordination and communication of services;
- clear statements of current comprehensive assessment and ongoing treatment plans;
- an integration point for communication and coordination with community-based care providers and other community resources;
- facilities that are tailored to children's needs, and;
- opportunity to encourage the parents/child to participate in treatment planning, allowing for timely feedback and discussion of concerns with specialists.

The following types of CMS Clinics are covered by CSHCS:

- AIDS
- Amputee/Limb Deficiency
- Apnea
- Cardiology
- Cleft Lip/Palate/Facial Anomaly
- Cystic Fibrosis

- Diabetes
- Endocrinology
- Feeding Clinic
- Gastroenterology/Nutritional Deficiencies
- Genetics (limited access is covered by CSHCS)
- Hematology/Oncology
- Hemophilia
- Immunology/Rheumatology
- Lead Toxicity
- Metabolic Disease
- Multiple Disability/Chronic Disease
- Muscular Dystrophy
- Myelodysplasia/Spina Bifida
- Nephrology/Urology
- Neurology
- Pulmonary/Severe Asthma
- Seizures
- Sickle Cell

A list of CMS clinics and their locations is included at the end of this section.

12.6 Commonly Requested Non-Covered Services

Some of the commonly requested services that are not covered by CSHCS are as follows:

- Infertility treatment including sperm/ovum storage
- Mental Health Services
- Substance Abuse Treatment Services

Experimental Care (any procedure or service which is not generally accepted treatment among specialists who treat the condition).

- **CHILDREN'S MULTIDISCIPLINARY SPECIALTY CLINICS**

Marlene Pryson, Clinic Coordinator **Bronson Methodist Hospital/KCMS** 1000 Oakland Drive Kalamazoo, MI 49008 (269) 337-6437 Fax: (269)-337-6427 Laurie Campbell – contact for contracts 269-341-8974 ***Cardiology, Cleft Lip/Palate/Facial, Cystic Fibrosis, Diabetes, Endocrinology, Hematology/Oncology, Hemophilia, Multiple Handicap/Disability/ Chronic Disease, Myelodysplasia/Spina Bifida and Pulmonary/Severe Asthma***	Susan Caister, Coordinator **Covenant Medical Center/Health Care** 1447 N. Harrison Saginaw, MI 48602 (989) 583-5188 Carol Keinath, Manager ***Diabetes and Endocrinology***	Layna Korcal, Clinic Director **E.W. Sparrow Hospital** 1200 E. Michigan Avenue Lansing , MI 48909 (517) 364-5415 ***Apnea, Cleft Lip/Palate/Facial and Myelodysplasia/Spina Bifida***
Leslie Studey, Clinic Director **Helen DeVos Children's Hospital** 100 Michigan Street NE, MC-004 Grand Rapids, MI 49503 (616) 391-3057 Fax: (616)-391-7103 ***Cleft Lip/Palate/Facial, Cystic Fibrosis, Hematology/Oncology, Hemophilia, Lead Toxicity, Sickle Cell Disease***	Katherine Coffield, Clinic Director **Hurley Medical Center** 4th Floor School of Nursing 1 Hurley Plaza Mott Children's Health Ctr. 2nd Floor Flint, MI 48503 (810) 762-6423 Bill McGregor – contact for contracts Phone 810-257-9685 ***Apnea, Cleft Lip/Palate/Facial, Cystic Fibrosis and Hemophilia***	Sue Britton, Clinic Coordinator Cindy Dulany, RN - Nurse **Marquette General Health System** 580 W. College Avenue Marquette, MI 49855 (906) 225-4777 Fax: (906)-225-4830 ***Cardiology, Cleft Lip/Palate/Facial, Hematology/Oncology, Hemophilia, Multiple Handicap/Chronic Disease, Neurology and Pulmonary/Severe Asthma***
Francie Dietrich, Department Director Connie Brown-Olds, Clinic Manager **Mary Free Bed Hospital** 235 Wealthy Street SE Grand Rapids, MI 49503 (616) 356-1900 Fax: (616)493-9639 Amputee/Limb Deficiency, Multiple Handicap/Chronic Disease and Myelodysplasia/Spina Bifida	Susan Young, M.D., Clinic Director Patricia O'Hair, Clinic Coordinator **Oakwood Center for Exceptional Families** 18501 Rotunda Drive Dearborn , MI 48124 (313) 791–4335 Fax: (313) 791–4822 Apnea and Multiple Handicap/Chronic Disease ***Send copy of contract to Gregory Witbeck***	Jaclynn Cunningham, Clinic Director **William Beaumont Hospital Outpatient Clinic** 3535 West 13 Mile Road Royal Oak, MI 48073 (248) 551-3000 Fax: (248)-551-7561 Cleft Lip/Palate/Facial
Deb Garvey, Department Administrator **Michigan State University Dept. of Pediatrics** B240 Life Sciences East Lansing, MI 48824-1317 (517) 355-4664 ***Cardiology, Chronic Illness, Cystic Fibrosis, Diabetes, Endocrinology, Genetics, Hematology, Hemophilia, Immunology/ Rheumatology and Pulmonary/Severe Asthma, Medical Home Model***	Ilene G. Phillips, Associate Director **University of MI Medical Center** 1500 East Medical Center Drive Ann Arbor, MI 48109-0244 (734) 764-2092 Hosp. Pager – X8606 ***AIDS, Cleft Lip/Palate/Facial, Chronic Illness, Diabetes, Gastroenterology/Nutritional Deficiencies, Hematology/Oncology, Hemophilia, Metabolic Disease and Pulmonary/Severe Asthma, Weight Management***	

SECTION 13: CARE COORDINATION

Effective for Services Authorized/Rendered On or After March 15, 2010

Those eligible to receive care coordination services include:

Persons enrolled in CSHCS with identified need for care coordination services (see the Requirements section for details regarding care coordination requirements).

Local Health Departments (LHDs) must meet the following care coordination requirements:

1. **Demonstrated care coordination experience in coordinating and linking such community resources as required by the target population**
2. **An administrative capacity to insure commonly accepted levels of service quality**
3. **A financial management capacity and system that provides documentation of services and costs**
4. **Capacity to document and maintain individual case records in accordance with State requirements and accepted standards for record retention**

Requirements for Care Coordination Services

Care coordination must be provided by qualified local health department/CSHCS staff who are trained in the service needs of the CSHCS population and demonstrate skill and sensitivity in communicating with children with special needs and their families. Exceptions may be made if comparable qualifications are documented.

CSHCS care coordination, as defined in this policy, is to be provided as needed and reimbursed to only one CSHCS care coordinator. However, certain care coordination services as described in the Reimbursement section are still required of the LHD and reimbursable as applicable even when the client/family is receiving CSHCS care coordination services from a provider external to the LHD. When more than one provider of care coordination is assisting a family, coordination of services is required.

This policy contains two levels of care coordination—Level I: Plan of Care (POC) and Level II: Standard Care Coordination (SCC) that may be provided when needed and the client/family agrees to the services.

Procedures for Care Coordination Services

The Level I Plan of Care (POC) is a client-specific, comprehensive care/service plan document that must be developed by a registered nurse or licensed social worker in partnership with the client/family. Input from the CSHCS program representative, the primary care provider and other involved disciplines is encouraged.

The POC must include the following elements:

- **Client summary/assessment**
  - **Client's name, date of birth, recipient ID, address, phone, parent(s)/guardian(s) name and contact information**
  - **Client's CSHCS qualifying diagnosis(es)**
  - **All significant health concerns or needs**
  - **Client's insurance coverage; medical, social, educational, and functional status**
  - **Date the POC was developed and date(s) the POC was updated**
  - **The Family Phone Line number**
  - **Complete listing of current medical care providers, pharmaceuticals, and all equipment in use or intended to be acquired.**
- **Dated list of each problem/concern**
- **Corresponding problem-specific goal(s) unique to each client, with family input**
- **Identification of appropriate intervention(s) and designation of person who will provide each intervention**
- **Periodic evaluation of progress towards goal achievement or barriers encountered.**

The client/family signature indicates participation in and agreement with POC development. The client/family signature is required for the POC to be determined complete. When good faith efforts to acquire the original signature have failed, clients/families may give verbal approval over the phone for the case manager to sign on their behalf. Signatures performed on behalf of the client/family are not to exceed 10% of the overall signature rate for the fiscal year.

A signed consent to release protected health information must be obtained from the client/family in order to share the POC with the identified primary care provider. The client/family signature area can include the agreement to release information to the primary care provider or the release can be done separately. If deemed appropriate and permission has been obtained, the plan of care may be shared with other care providers such as a subspecialist, school, etc.

Level I: Plan of Care, as a standard, consists of one (1) POC within a given eligibility year. Any needed revisions during the year would be considered Level II: SCC. A Level I: POC can occur more often based upon the professional judgment of the registered nurse or licensed social worker evaluating the needs of the client/family. Staff must document in the client file the reason and circumstances that resulted in a need for more than one full POC to be developed within the same eligibility year.

LHD staff are strongly encouraged to contact their CSHCS-assigned regional nurse consultant to discuss the circumstances regarding the need for more than one POC within the eligibility year.

Level II: Standard Care Coordination (SCC) must be provided by a registered nurse, social worker, or paraprofessional under the direction and supervision of a registered nurse. SCC consists of interaction with the client/family and others involved with care of the client by telephone, in person or in writing. Care coordination activities include, but are not limited to, arranging for service delivery from CSHCS qualified providers, client advocacy, assisting with needed social, educational, or other support services, facilitating transitional services for CSHCS/Medicaid clients at age 21 regarding the Medicaid Health Plan selection process, and processing Children with Special Needs Fund applications. In addition, these services must: 1) involve multiple contacts; 2) and be substantive. Clients are eligible for a maximum of ten (10) care coordination units per eligibility year. Any services beyond ten require prior approval by MDCH by sending a detailed request including documentation and the rationale for additional services to:

Michigan Department of Community Health
CSHCS Quality Section
Lewis Cass Bldg., 6th Floor
320 S. Walnut St.
Lansing, MI 48913

LHD staff are strongly encouraged to contact their CSHCS-assigned regional nurse consultant to discuss the circumstances regarding the need for more than ten care coordination units within the eligibility year.

SCC may be extended to a family whose enrolled child has died for up to six months following the death (maximum of four units) if services are needed and the family agrees to the services.

SCC may be extended to clients who age out of CSHCS and are likely to become enrolled in a Medicaid Health Plan (MHP) for up to six months after the client turns 21 as described in the policy document "Transitioning CSHCS Clients with Medicaid Who Are Aging-out of CSHCS".

Reimbursement

Care coordination is reimbursed through the CPBC/FSR system based on the "fixed unit rate" method.

The fee for Level I: POC reimbursement is as follows:

Annual Plan of Care in the home or home-like setting that requires the care coordinator to travel to a non-LHD site:	**$150.00**
Annual Plan of Care over the telephone or face-to-face at the LHD:	**$100.00**

Reimbursement for Level I: Clients are eligible for one (1) POC within a given eligibility year.

The POC may only be developed and billed when the client/family participates in the process.

The fee for Level II: SCC reimbursement is $30.00 per unit. A maximum of 10 units per client per eligibility year is reimbursable. Refer to Case management/care coordination Guide for assistance in determining the services that are considered care coordination.

To be reimbursed, the unit rates associated with the services rendered for both Level I: POC and Level II: SCC must be detailed on the CSHCS Case Management and Care Coordination Supplemental Attachment to the CPBC/FSR. Total amounts for both Level I: POC and Level II: SCC should be added together and included on line 24 of the FSR as "CSHCS Care Coordination" and should reconcile with the amounts detailed on the Supplemental Attachment for Care Coordination.

Care coordination cannot be billed for clients also receiving case management services during the same billing quarter. In the event care coordination services are no longer appropriate, and case management services are needed, the change in services may only be made at the beginning of the next billing quarter.

Collaboration with External Care Coordinator or Case Manager

Some families receive CSHCS care coordination or case management through providers who are external to the LHD. As a general rule, families are not to receive services through both the LHD and the external provider. However, because of CSHCS program requirements for LHDs, there are circumstances that require the LHD to provide assistance to the families receiving care coordination or case management services external to the LHD. As an example, it is still the responsibility of the LHD to contact all families when their renewal is coming due and medical and/or financial information has not yet been submitted to CSHCS to assist the family in maintaining coverage.

The LHD assistance may at times become complex enough to fall under the definition of care coordination. When this occurs, the LHD is allowed to bill SCC for families who primarily receive care coordination or case management from an external provider. When more than one provider of care coordination or case management assists the family, coordination of services between the providers is required. The following is a listing of the services or benefits for which an LHD can or may be required to assist a family who has an external care coordination or case management provider.

The LHDs are required to assist families with the following services if needed. External care coordination or case management providers are not authorized to provide this assistance.

- **Standard transportation assistance for mileage and lodging, etc.**
- **Diagnostic referral regarding conditions for which the client is not currently CSHCS covered**

Assistance with payment agreements

The LHDs are required to assist families with the following services if needed, even though the external care coordination or case management providers are also authorized to provide this assistance.

- **Follow-up on medical information needed for CSHCS renewal**
- **CSN Fund applications**
- **Insurance premium payment applications**

LHDs must notify the Policy and Program Development section when billing for SCC for each client with an external care coordination or case management provider.

Documentation

Documentation of types of activities, staff involved and resolution must be maintained in the client's case file. LHDs must maintain documentation on a paper or computer log for all care coordination services. This documentation must include at a minimum: client name; CSHCS ID number; date(s) of service, date of the FSR and Supplemental Attachment on which the services were billed. These records must be maintained following approved record retention guidelines and be available for review and audit purposes. The care coordination logs will be requested periodically by MDCH on a random audit basis to monitor overall compliance with program requirements.

CM/CC guide is located at the end of the Case Management Section

13.1 Care Coordination After The Death Of The CSHCS Client

In the event of the death of the CSHCS client, CC can continue up to six (6) months following the death (maximum of four units). Care coordination services should be conducted in conjunction with the family and other support services providers. Services may include but are not limited to: assistance with funeral arrangements; notification of physicians and providers; cancellation of appointments; arranging for the disposition of durable medical equipment (DME) from the home, assisting the family with obtaining bereavement/counseling services, consolidation of billing information to facilitate correct responses to billers/agency staffers, and/or development of community supports services following the departure of the (myriad) many health professional services.

If CC is continued after death the LHD should note the client's death date and a brief statement of the family needs in the CC log.

Several examples of POC can be found in Appendix K. Also, see the Bereavement information in Section 27.

SECTION 14: CASE MANAGEMENT

Effective for Services Authorized/Rendered On or After March 15, 2010

Those eligible to receive Case Management services include persons enrolled in CSHCS or Medicaid with identified need for case management services (see the Requirements section for details regarding case management requirements) who are:

1. **Aged 0-21 with a Michigan Department of Public Health, Division of Children's Special Health Care Services medically eligible diagnosis; or**
2. **SSI-Disabled Children's Program clients 0-16; or**
3. **Aged 21 and over with either cystic fibrosis or coagulation defects**

Case Management provider organizations must be certified by the single-State agency as meeting the following criteria:

1. **Demonstrated capacity to provide all core elements of Case Management services including:**
   a. **Comprehensive client assessment**
   b. **Comprehensive care/service plan development**
   c. **Linking/coordination of services**
   d. **Monitoring and follow-up of services**
   e. **Reassessment of the client's status and needs**
2. **Demonstrated Case Management experience in coordinating and linking such community resources as required by the target population**
3. **Demonstrated experience with the target population**
4. **A sufficient number of staff to meet the Case Management service needs of the target population**
5. **An administrative capacity to insure quality of services in accordance with State and Federal requirements**
6. **A financial management capacity and system that provides documentation of services and costs**
7. **Capacity to document and maintain individual case records in accordance with State and federal requirements**

Requirements for Case Management Services

Each case manager must be licensed to practice as a registered professional nurse in the State of Michigan and be employed as a Public Health nurse at the entry level or above by a local health department, or be able to demonstrate to MDCH that comparable qualifications are met. Clients/families eligible for case management services typically have complex medical care and/or complex psycho-social situations that would benefit from intervention and direction provided by an outside, independent professional. Eligible clients include but are not limited to the Private Duty Nursing (PDN) population. Eligible families may receive, but are not required to accept, case management services.

Procedures for Case Management Services

The Case Management Plan of Care (POC) is a client-specific, comprehensive care/service plan document that must be developed by a public health nurse (or a nurse with comparable qualifications) in partnership with the client/family. Input from the CSHCS program representative, the primary care provider and other involved disciplines is encouraged.

The POC must include the following elements:

- **Client summary/assessment**
  - **Client's name, date of birth, recipient ID, address, phone, parent(s)/guardian(s) name and contact information**
  - **Client's CSHCS qualifying diagnosis(es)**
  - **All significant health concerns or needs**
  - **Client's insurance coverage; medical, social, educational, and functional status**
  - **Date the POC was developed and date(s) the POC was updated**
  - **The Family Phone Line number**
  - **Complete listing of current medical care providers, pharmaceuticals, and all equipment in use or intended to be acquired.**
- **Dated list of each problem/concern**
- **Corresponding problem-specific goal(s) unique to each client, with family input**
- **Identification of appropriate intervention(s) and designation of person who will provide each intervention**
- **Periodic evaluation of progress towards goal achievement or barriers encountered.**

The client/family signature indicates participation in and agreement with POC development. The client/family signature is required for the POC to be determined complete. When good faith efforts to acquire the original signature have failed, clients/families may give verbal approval over the phone for the case manager to sign on their behalf. Signatures performed on behalf of the client/family are not to exceed 10% of the overall signature rate for the fiscal year.

A signed consent to release protected health information must be obtained from the client/family in order to share the POC with the identified primary care provider. The client/family signature area can include the agreement to release information to the primary care provider or the release can be done separately. If deemed appropriate and permission has been obtained, the plan of care may be shared with other care providers such as a subspecialist, school, etc.

A Home Environment Needs Survey (HENS) is required for clients/families receiving PDN services. LHDs can opt to complete a HENS for clients not receiving PDN, but it is not required. (HENS survey form can be found at the end of this section).

Clients are eligible for a maximum of six (6) case management units per eligibility year. Any services beyond six units require prior approval by MDCH by sending a detailed request including documentation and the rationale for additional services to:

Michigan Department of Community Health
CSHCS Quality Section
Lewis Cass Bldg., 6th Floor
320 S. Walnut St.
Lansing, MI 48913

LHD staff are strongly encouraged to contact their CSHCS-assigned regional nurse consultant to discuss the circumstances regarding the need for more than six case management units within the eligibility year.

Reimbursement

Case management is reimbursed through the CPBC/FSR system based on the "fixed unit rate" method. The fee for case management is $201.58 per set of services constituting a unit which requires that services be provided in the home setting (or other noninstitutional settings based on family preference), and be provided primarily face-to-face. Some activities contained within the set of services will best be performed via telephone or other method. Case management service reimbursement includes the costs of travel, POC development, planning, documentation, completion of a HENS (see attached) and service coordination.

To be reimbursed, the unit rate associated with the services rendered must be included on the CSHCS Case Management and Care Coordination Supplemental Attachment to the CPBC FSR. Total amounts for Case Management should be included on line 24 of the FSR as "CSHCS Case Management" and should reconcile with the amounts detailed on the Supplemental Attachment for Case Management.

Case Management cannot be billed for clients also receiving Level I: POC or Level II: Standard Care Coordination (SCC) services during the same billing quarter. In the event case management services are no longer required, but Level II: SCC services would be of assistance, converting from case management to care coordination is allowable at the beginning of the next billing quarter.

Collaboration with External Care Coordinator or Case Manager

Some families receive CSHCS care coordination or case management through providers who are external to the LHD. As a general rule, families are not to receive services through both the LHD and the external provider. However, because of CSHCS program requirements for the LHDs, there are circumstances that will require the LHD to provide assistance to the families receiving case management or care coordination services external to the LHD due to programmatic requirements. As an example, it is still the responsibility of the LHD to contact all families when their renewal is coming due and medical and/or financial information has not yet been submitted to CSHCS to assist the family in maintaining coverage.

The LHD assistance may at times become complex enough to fall under the definition of care coordination. When this occurs, the LHD is allowed to bill SCC for families who primarily receive case management or care coordination from an external provider. When more than one provider of case management or care coordination assists the family, coordination of services between the providers is required. The following is a listing of the services or benefits for which an LHD can or may be required to assist a family who has an external case management or care coordination provider.

The LHDs are required to assist families with the following services if needed. External case management or care coordination providers are not authorized to provide this assistance.

- **Standard transportation assistance for mileage and lodging, etc.**
- **Diagnostic referral regarding conditions for which the client is not currently CSHCS covered**
- **Assistance with payment agreements**

The LHDs are required to assist families with the following services if needed, even though the external case management or care coordination providers are also authorized to provide this assistance.

- **Follow-up on medical information needed for CSHCS renewal**
- **CSN Fund applications**
- **Insurance premium payment applications**

LHDs must notify the Policy and Program Development section when billing for SCC for each client with an external case management or care coordination provider.

Documentation

Documentation of the types of activities, the staff involved and the resolution must be maintained in the client's case file. LHDs must maintain documentation on a paper or computer log for all case management services. This documentation must include at a minimum: client name, CSHCS ID number, date(s) of service, and date of the FSR and Supplemental Attachment on which the services were billed. These records must be

maintained following approved record retention guidelines and be available for review and audit purposes. The case management logs will be requested periodically by MDCH on a random audit basis to monitor overall compliance with the program requirements.

Several examples of POC can be found in Appendix K.

CHILDREN'S SPECIAL HEALTH CARE SERVICES

CASE MANAGEMENT/CARE COORDINATION GUIDE – 08/01/05

OUTREACH & ADVOCACY (Categorical Allocation)	**CARE COORDINATION** Over phone, in writing or in person Non-routine, multiple contacts, substantive May use 30 minutes as guideline for 1 unit ($30 per unit, maximum of 10 units per client per eligibility period)	**CASE MANAGEMENT** In-home intervention provided by PHN employed by local health department Comprehensive assessment & care plan development Linking/coordination, monitoring and follow-up of services, reassessment of status & needs ($201.58 per service up to 6 services/eligibility period)
OUTREACH • Provide general program information to families, providers, public, other agencies • Arrange & authorize diagnostic referrals • Request/submit medical information for eligibility determination • Annual contact with families in writing or of short duration not requiring complex follow-up • Promote awareness of CSHCS through presentations & other networking opportunities	**OUTREACH** • Coordinating referrals for eligible services/equipment, for client and/or other family members, identified in annual encounters with family (e.g. dental, community clinics, health insurance, therapy, preschool, etc.)	**OUTREACH** • Same as Care Coordination but as part of written plan of care carried out through in-home intervention as applicable.
ADVOCACY • Assisting with completion of CSHCS Application & Financial Assessment forms, in person or over the phone. • Answering questions & listening to concerns families have to help them advocate on their own behalf	**ADVOCACY** • Intervention at school on behalf of a child regarding their specific health issues • Working with the school/ISD to get needed school services • Attending multidisciplinary meetings, wraparound, etc. • Helping families get large equipment items & troubleshooting equipment delays • Intervention to obtain needed social, education or other support services • Accompanying clients to appointments	**ADVOCACY** • Same as Care Coordination but as part of written plan of care carried out through in-home intervention as applicable
SERVICE DELIVERY • Referral and information for service delivery • Add/delete providers as indicated	**SERVICE DELIVERY** • Arranging service delivery from providers • Discharge planning • Coordinating services w/multiple agencies	**SERVICE DELIVERY** • Same as Care Coordination but as part of written plan of care carried out through in-home intervention as applicable

OUTREACH & ADVOCACY	CARE COORDINATION	CASE MANAGEMENT
(Categorical Allocation)	Over phone, in writing or in person Non-routine, multiple contacts, substantive May use 30 minutes as guideline for 1 unit ($30 per unit, maximum of 10 units per client per eligibility period)	In-home intervention provided by PHN employed by local health department Comprehensive assessment & care plan development Linking/coordination, monitoring and follow-up of services, reassessment of status & needs ($201.58 per service up to 6 services/eligibility period)
CHILDREN WITH SPECIAL NEEDS FUND • Describe CSN Fund & provide information	**CHILDREN WITH SPECIAL NEEDS FUND** • Assist families with CSN Fund applications including obtaining bids & follow-up	**CHILDREN WITH SPECIAL NEEDS FUND** • Same as Care Coordination but as part of written plan of care carried out through in-home intervention as applicable
TRANSPORTATION • Describe and provide information regarding CSHCS transportation assistance and other resources • Provide forms for transportation assistance	**TRANSPORTATION** • Arrange for in & out of state travel including transportation, meals or lodging • Assist in obtaining reimbursement	**TRANSPORTATION** • Same as Care Coordination but as part of written plan of care carried out through in-home intervention as applicable
BILLING • Add providers • Quick answers to simple questions • Referral to Beneficiary Help Line	**BILLING** • Intervention on complex billing issues such as multiple contacts with patient accounts, collection agencies and/or the state office	**BILLING** Same as Care Coordination but as part of written plan of care carried out through in-home intervention as applicable
TRANSITION • Identify area providers who will serve age-out population • Identify clients about to age out of CSHCS and make needed referrals	**TRANSITION** • Transition services for CSHCS/Medicaid clients about to age out (follow policy and assist with transition into Medicaid Health Plan for up to six months following 21st birthday) • Transition services for clients turning 21 who do not have Medicaid	**TRANSITION** • Same as Care Coordination but as part of written plan of care carried out through in-home intervention as applicable
RESPITE • Inform families of available services or application processes • Refer families to potential resources	**RESPITE** • Help families apply for CSHCS skilled nursing respite • Identify other appropriate respite resources for family • Help families apply for other respite resources • Assist family in development of alternative resources (e.g. training family or community support system members)	**RESPITE** • Same as Care Coordination but as part of written plan of care carried out through in-home intervention as applicable

OUTREACH & ADVOCACY	CARE COORDINATION	CASE MANAGEMENT
(Categorical Allocation)	Over phone, in writing or in person Non-routine, multiple contacts, substantive May use 30 minutes as guideline for 1 unit ($30 per unit, maximum of 10 units per client per eligibility period)	In-home intervention provided by PHN employed by local health department Comprehensive assessment & care plan development Linking/coordination, monitoring and follow-up of services, reassessment of status & needs ($201.58 per service up to 6 services/eligibility period)
HOSPICE • Inform families of available services or application processes	**HOSPICE** • Arrange for hospice services • Follow-up on CSHCS issues created prior to hospice enrollment	**HOSPICE**
INSURANCE PREMIUM PAYMENT PROGRAM • Inform families of available service • Answer general questions	**INSURANCE PREMIUM PAYMENT PROGRAM** • Assess feasibility • Assist with application, obtaining information from employer and/or insurance company	**INSURANCE PREMIUM PAYMENT PROGRAM** • Same as Care Coordination but as part of written plan of care carried out through in-home intervention as applicable
OTHER SERVICES (Early On, MIChild, WIC, Healthy Kids, Medicare, etc.) • Provide information & referral	**OTHER SERVICES** (Early On, MIChild, WIC, Healthy Kids, Medicare, etc.) • Assist with completion of applications (such as MIChild/Healthy Kids) • Completion of developmental assessment for Early On or Special Education • Coordinated Plan of Care with Early On IFSP • Consultation with school and family In the development of IEP • Follow-up to link families with other needed services	**OTHER SERVICES** (Early On, MIChild, WIC, Healthy Kids, Medicare, etc.) • Same as Care Coordination but as part of written plan of care carried out through in-home intervention as applicable
PRIVATE DUTY NURSING • Answer questions	**PRIVATE DUTY NURSING** • Collaborate with home health, private duty provider (if not billing case management)	**PRIVATE DUTY NURSING** • Collaborate with home health, private duty nursing provider • Develop care plan for case management, in partnership with family • Provide in home intervention to carry out plan of care

Michigan Department of Community Health
Children's Special Health Care Services

Home Environment Needs Survey

Date completed:		Completed by:	

Child's Name: _____
Date of Birth: CSHCS ID:

Address:			
Telephone Number:		Alternate Number:	
Child's Caregiver:		Relationship to Child:	

Do you understand Children's Special Health Care Services program and the services that they provide?	☐ YES ☐ NO
Do you have an Early On IFSP? (if child is 0 – 3 years)	☐ YES ☐ NO ☐ N/A
Do you have an IEP through school? (if child is >3 years)	☐ YES ☐ NO ☐ N/A

I. Alternate caregiver/Training needed

1. Does your alternative caregiver understand his/her responsibilities as an alternate caregiver?	☐ YES ☐ NO
2. Have you and your alternative caregiver completed CPR training?	☐ YES ☐ NO
3. Do you feel comfortable providing all the care your child needs?	☐ YES ☐ NO

II. Home Environment/Supplies and Equipment

1. Do you have a "land line" telephone?	☐ YES ☐ NO
Do you have a cell phone?	☐ YES ☐ NO
If you do not have a phone, you can keep a charged cell phone for 911 calls.	

2. Type of Housing [check all that apply]: ☐ House ☐ Apartment ☐ Manufactured home

☐ Other (e.g. shelter, relative's home)		☐ Rent ☐ Own

3. Where will your child spend the majority of his/her time?
   Identify: _____
   Is there a privacy issue for your family? ☐ YES ☐ NO

4. Does this room provide adequate space for equipment, supplies, and nursing staff?	☐ YES ☐ NO

5. Will you need articles for your child prior to coming home?	☐ YES ☐ NO ☐ N/A
If yes, please explain:	

6. Do you have concerns about the physical state of your home?	☐ YES ☐ NO

7. Are you aware of any building code violations in your home or apt?	☐ YES ☐ NO
If yes explain	

8. Are there any changes in your home that you feel should be made prior to your child coming home?	
	☐ YES ☐ NO ☐ N/A

9. How do you plan to store medications?	

10. Does your child need specialized equipment, such as a ventilator?	☐ YES ☐ NO
If yes, has the medical equipment company completed an evaluation of the electrical system in your child's room?	☐ YES ☐ NO
Date:	
Recommendations:	

11. Is electrical work needed in your home?	☐ YES ☐ NO
If yes, how do you plan to cover the cost of this work?	

12. Are the following items in your home satisfactory to you?

Exterior (including stairs)	☐ YES ☐ NO
Parking for nurses	☐ YES ☐ NO
Address visible from the road	☐ YES ☐ NO
Neighborhood safety	☐ YES ☐ NO
Exits	☐ YES ☐ NO
Access into and out of your home	☐ YES ☐ NO
Lighting interior/exterior	☐ YES ☐ NO
Electrical outlets & circuits	☐ YES ☐ NO
Circuits labeled	☐ YES ☐ NO
Emergency bedside lighting (battery)	☐ YES ☐ NO
Generator (if needed for important medical equipment)	☐ YES ☐ NO ☐ N/A
Heating	☐ YES ☐ NO
Ventilation	☐ YES ☐ NO
Air conditioning	☐ YES ☐ NO
Sanitation/Waste removal/Pest control	☐ YES ☐ NO
Plumbing	☐ YES ☐ NO
Supply	☐ YES ☐ NO
Refrigeration	☐ YES ☐ NO
Fire extinguisher	☐ YES ☐ NO
Smoke detectors	☐ YES ☐ NO

13. Do you have a fire extinguisher	☐ YES ☐ NO
If yes, do you know how to use it?	☐ YES ☐ NO
If no, how do you plan to get one?	

14. Have the following community services been notified about your child's condition and the need for uninterrupted service?	
Telephone	☐ YES ☐ NO
Fire Dept/Rescue	☐ YES ☐ NO
Electrical Company	☐ YES ☐ NO
Road Commission	☐ YES ☐ NO
Other	
If your child needs specialized equipment, contact your electric company to see if you qualify for a special electric rate.	

15. Are your utility payments up to date?

Telephone	☐ YES ☐ NO
Electrical	☐ YES ☐ NO
Heating	☐ YES ☐ NO
Water	☐ YES ☐ NO

16. Do you have a fire evacuation plan?	☐ YES ☐ NO
Comments:	

17. Do you have a tornado plan?	☐ YES ☐ NO
It will be important to discuss your fire evacuation and tornado plans with the nurses.	

18. Do you keep firearms in your home?	☐ YES ☐ NO
If yes, are visitors aware of your firearms?	☐ YES ☐ NO
If yes, what is your safety plan for firearms in the home?	

19. Please comment on the following transportation issues:

Do you have an appropriate child safety seat?	☐ YES ☐ NO ☐ N/A
Do you need a special stroller?	☐ YES ☐ NO ☐ N/A
Do you have a handicap-parking permit?	☐ YES ☐ NO
Do you need transportation assistance to medical appointments?	☐ YES ☐ NO

20. Do you have any pets and/or other animals in the home or with which you have regular contact? (i.e. work in a pet store, etc.)	☐ YES ☐ NO

21. Do you have a plan for your pets when your child is home (e.g. allergies, safety, etc.)?	
	☐ YES ☐ NO

22. Is(are) the pet(s) a concern for nursing staff providing care in the home?	☐ YES ☐ NO

23. The following pertain to lead risks that might be present in your home:

Was your home built before 1950?	☐ YES ☐ NO
Was your home built before 1978 AND remodeled in the last year?	☐ YES ☐ NO
Is there chipping or peeling paint in your home?	☐ YES ☐ NO
Is there chipping or peeling paint in another location where your child spends more than two hours per day or more than three days per week?	☐ YES ☐ NO

24. Have you received the CSHCS booklet *Being Prepared for an Emergency*?	☐ YES ☐ NO
Do you have any questions about how to use the booklet?	☐ YES ☐ NO
Another good resource that you might be interested in is *Special Care for Special Kids* located at http://www.michigan.gov/documents/mdch/1-21_SpecialCareGuide_203487_7.pdf	

III. Family Health Care

1. Will the health care needs of other family members require extra time from you?	
	☐ YES ☐ NO

2. What arrangements do you have for your children in case you have to leave quickly?

3. Do you have a plan for child-care in case of your own illness?	☐ YES ☐ NO

4. Does anyone in the home smoke?	☐ YES ☐ NO
If yes, what is your plan for a smoke-free environment for your child?	

IV. Peer/Professional Support

1. Bringing home a child who requires very special care can cause some family members to feel stressed and anxious. Sometimes talking to someone or counseling can help resolve these feelings. Would you be interested in a referral for counseling for yourself or another family member?	
	☐ YES ☐ NO

V. Family/Non-Professional Support

1. Would you like to know about local parent support groups?	☐ YES ☐ NO

2. Would you like to talk with a parent of a child with the same or similar condition?	
	☐ YES ☐ NO

3. Are there specific religious or cultural traditions or family practices in your home that you would like honored?	☐ YES ☐ NO
If yes, please explain:	

(Component of the Case Management Policy and Procedure)
lt:9/1/08

SECTION 15:

SECTION 16: PRIVATE DUTY NURSING (PDN)

This section is for information purposes only. PDN is not a CSHCS covered benefit.

Private duty nursing (PDN) is a Medicaid benefit when provided in accordance with the policies and procedures outlined in the Medicaid Provider Manual. Providers must adhere to all applicable coverage limitations, policies and procedures set forth.

PDN is covered for clients under age 21 who meet the medical criteria in this section. If the beneficiary is enrolled in or receiving case management services from one of the following programs, that program authorizes the PDN services.

- Home and Community-Based Services Waiver for the Elderly and Disabled (known as the MI Choice Waiver)
- Children's Waiver (Community Mental Health Service Program of CMHSP
- Habilitation Supports Waiver of CMHSP

For a client who is not receiving services from one of the above programs (e.g., Medicaid client who is not on a waiver), the PRD reviews the request for authorization and authorizes the services if the medical criteria and general eligibility requirements are met.

Clients who are receiving PDN services through one Medicaid Program cannot seek supplemental PDN hours from another Medicaid Program (i.e., MI Choice Waiver, Children's Waiver, Habilitation Supports Waiver).

PDN must be ordered by a physician and provided by a Medicaid enrolled private duty agency, a Medicaid enrolled registered nurse (RN), or a Medicaid enrolled licensed practical nurse (LPN) who is working under the supervision of an RN (per Michigan Public Health Code). It is the responsibility of the LPN to secure the RN supervision.

For clients age 21 and older who have aged out of CSHCS, PDN is a Medicaid waiver service that may be covered for qualifying individuals enrolled in the MI Choice Waiver or Habilitation Supports Waiver.

When PDN is provided as a waiver service, the waiver agent must be billed for the services. (Refer to the Transition Resource Manual for details).

16.1 Prior Authorization

PDN services must be authorized by one of the above-mentioned programs before services are provided. Prior authorization of a particular PDN provider to render services within the hours of PDN coverage as determined appropriate considers the following factors:

- Available third party resources.
- Client/family choice.
- Client's medical needs and age.
- The knowledge and appropriate nursing skills needed for the specific case.
- The understanding of the concept and delivery of home care and linkages to relevant services and health care organizations in the area served.

The Prior Authorization for Private Duty Nursing (PDN) form (MSA-0732; Appendix D) must be submitted when requesting PDN services for persons with Medicaid coverage. This form is not to be used for clients enrolled in, or receiving case management services from, the Children's Waiver, Habilitation Supports Waiver, or MI Choice Waiver.

16.2 General Eligibility Requirements

The client is eligible for PDN coverage when all of the following requirements are met:

- The client is eligible for Medicaid in the home/community setting (i.e., in the non-institutional setting). Questions regarding whether a CSHCS client may become Medicaid eligible through TEFRA can be directed to the CSHCS insurance specialist (See Appendix A).
- The client is under the age of 21 and meets the medical criteria for PDN.
- PDN is appropriate, considering the client's health and medical care needs.
- PDN can be provided safely in the home setting.

The client, family (or guardian), the client's physician, the Medicaid case manager, and RN (i.e., from the PDN agency or the Medicaid enrolled RN, or the supervising RN for the Medicaid enrolled LPN) have collaborated and developed an integrated plan of care (POC) that identifies and addresses the client's need for PDN. The PDN must be under the direction of the client's physician; the physician must prescribe/order the services. The POC must be signed and dated by the client's physician, RN (as described above), and by the client or the client's parent/legal guardian. The POC must be updated at least annually and must also be updated as needed based on the client's medical needs.

The purpose of the PDN benefit is to assist clients with medical care, enabling clients to remain at home. The benefit is not intended to supplant the care giving responsibility of parents, guardians, or other responsible parties (e.g., foster parents). There must be a primary caregiver (i.e., parent, guardian, significant other adult) who resides with a client under the age of 18 and the caregiver must provide a monthly average of a minimum of eight hours of care during a typical 24-hour period. The calculation of the number of hours authorized per month includes eight hours of care that will be provided by the caregiver during a 24-hour period, which are then averaged across the hours authorized for the month. The caregiver has the flexibility to use the monthly authorized hours as needed during the month.

The time a client is under the supervision of another entity or individual (e.g., in school, in day/child care, in work program) cannot be used to meet the eight hours of obligated care as discussed above, nor can the eight hours of care requirement for clients under age 18 be met by other public funded programs (e.g., MDCH Home Help Program), or other resources for hourly care (e.g., private health insurance, trusts, bequests, private pay).

For specific detailed information regarding medical eligibility criteria, determination of the client's intensity of care category, and the Decision Guide for Establishing the Maximum Amount of PDN to Be Authorized on a Daily Basis, refer to the PDN Chapter of the Medicaid Provider Manual.

SECTION 17: HOSPICE

LHD procedures for Hospice Benefit included at the end of this section

The CSHCS hospice benefit provides assistance to a client/family when end of life care related to the client's CSHCS qualifying diagnosis is appropriate. Hospice is intended to address the medical needs of the client with a terminal illness whose life expectancy is limited to six months or less.

Hospice services must be prior authorized. Prior authorization requests require medical documentation from the client's enrolled CSHCS subspecialist who is authorized (i.e., listed on the client's CSHCS authorized provider file) to treat the terminal illness. The medical documentation must include all of the following:

- **A statement of the terminal diagnosis.**
- **A statement that the client has reached the terminal phase of illness where the CSHCS subspecialist deems end of life care necessary and appropriate.**
- **Documentation of the need to pursue end of life care.**
- **A statement of limited life expectancy of six months or less.**
- **A proposed plan of care to address the service needs of the client that is:**
  - **less than 30 days old,**
  - **consistent with the philosophy/intent of the CSHCS hospice benefit as described above,**
  - **clinically and developmentally appropriate to the client's needs and abilities,**
  - **representative of the pattern of care for a client who has reached the terminal phase of illness, and**
  - **signed by the CSHCS subspecialist authorized to treat the terminal illness.**

The prior authorization time period does not exceed six months. To continue hospice services beyond six months, a new prior authorization request with medical documentation must be submitted as described above.

Hospice may not be authorized and/or continued for a CSHCS client when one or more of the following is true:

- **The medical documentation no longer supports the above criteria (e.g., change in condition, change in the plan of care, etc.).**
- **The family chooses to discontinue hospice.**
- **The medical services being rendered by the hospice provider are available through another benefit.**

Requests for hospice must be made in writing to CSHCS. (Refer Appendix B for contact information.) CSHCS responds to all prior authorization requests for hospice services in writing.

Hospice services must be prior authorized. Prior authorization requests require medical documentation from the client's enrolled CSHCS subspecialist who is authorized (i.e., listed on the client's CSHCS authorized provider file) to treat the terminal illness. The medical documentation must include all of the following:

- **A statement of the terminal diagnosis.**
- **A statement that the client has reached the terminal phase of illness where the CSHCS subspecialist deems end of life care necessary and appropriate.**
- **Documentation of the need to pursue end of life care.**
- **A statement of limited life expectancy of six months or less.**
- **A proposed plan of care to address the service needs of the client that is:**
  - **less than 30 days old,**
  - **consistent with the philosophy/intent of the CSHCS hospice benefit as described above,**
  - **clinically and developmentally appropriate to the client's needs and abilities,**
  - **representative of the pattern of care for a client who has reached the terminal phase of illness, and**
  - **signed by the CSHCS subspecialist authorized to treat the terminal illness.**

The prior authorization time period does not exceed six months. To continue hospice services beyond six months, a new prior authorization request with medical documentation must be submitted as described above.

Hospice may not be authorized and/or continued for a CSHCS client when one or more of the following is true:

- **The medical documentation no longer supports the above criteria (e.g., change in condition, change in the plan of care, etc.).**
- **The family chooses to discontinue hospice.**
- **The medical services being rendered by the hospice provider are available through another benefit.**

Requests for hospice must be made in writing to CSHCS. (Refer Appendix B for contact information.) CSHCS responds to all prior authorization requests for hospice services in writing.

SECTION 18: RESPITE BENEFIT

Respite services provide limited and temporary relief for families caring for clients with complex health care needs when the care needs require nursing services in lieu of the trained caregivers. Services are provided in the family home by hourly skilled and licensed nursing services as appropriate. To be eligible and authorized for respite, CSHCS must determine the client to have:

- **Health care needs that meet the following criteria:**
  - **That skilled nursing judgments and interventions be provided by licensed nurses in the absence of trained and/or experienced parents/caregivers responsible for the client's care;**
  - **That the family situation requires respite; and**
  - **That no other community resources are available for this service.**
- **No other publicly or privately funded hourly skilled nursing services in the home that would be duplicated by the CSHCS Respite benefit**
- **Service needs which can reasonably be met only by the CSHCS Respite benefit, not by another service benefit.**

Respite is reimbursed when provided by a Medicaid enrolled home health agency, a Medicaid enrolled registered nurse (RN) who is licensed to practice in the state of Michigan, or a Medicaid enrolled licensed practical nurse (LPN) who is licensed to practice in the state of Michigan and working under supervision according to the Michigan Public Health Code. It is the responsibility of the LPN to secure the appropriate supervision and maintain documentation that identifies the supervising professional. This is a CSHCS only benefit.

A maximum of 180 hours of CSHCS Respite services may be authorized per family during the 12 month eligibility period. When there is more than one respite-eligible client in a single home, the respite service is provided by one nurse at an enhanced reimbursement rate for the services provided to multiple clients. Allotted respite hours may be used at the discretion of the family within the eligibility period. Unused hours from a particular eligibility period are forfeited at the end of that period and cannot be carried forward into the next eligibility period.

Clients receiving services through any of the following publicly funded programs and benefits are not eligible for the CSHCS respite benefit:

- **Private Duty Nursing Benefit**
- **Children's Waiver**
- **Habilitation/Support Services Waiver**
- **MI Choice Waiver**

Requests for respite must be made in writing to CSHCS and include the following information:

- **The health care needs of the child;**
- **The family situation that influences the need for respite; and**
- **Other community resources or support systems that are available to the family (e.g., CMH services, DHS services, adoption subsidy, SSI, trust funds, etc.).**

The LHDs may submit information on the Application for Periodic Respite Service form (included in this section). CSHCS **responds to all requests for respite in writing**.

Michigan Department of Community Health
Children's Special Health Care Services

Application for Periodic Respite Services for Children
with Nursing Care Needs

Date of Request

Childs Name: Requested by:

Date of Birth: Completed by:

Diagnosis: County:

Address: Phone Number:

City: State Zip

1. What are the health care needs of the child?
   (Indicate treatment, medicines, frequency of care, activities which indicate the need for nursing care, etc.)

(Size is limited to 1200 characters)

2. What is the family situation or composition which influences the need for respite? What other community resources or support systems are available to the family? (Examples: Family support; CMH services; DHS services; foster care, or other financial support available to the family; adoption or medical subsidy; SSI; trust funds)

Proposed # of Hours Beginning Date:
Suggested Provider:
Contact Person Address:

Phone#: Fax#:
Federal ID#: (for agency)
Social Security#: (for private duty nurse)
License#: (for private duty nurse)

For MDCH Use Only

MDCH Nurse Consultant Decision: Approved: ☐ Denied: ☐

Rationale:

Total #of hours: Hourly Rate:

CSHCS Eligibility Period: From: To:

Respite Approval Period: From: To:

Signature: _____
MDCH Nurse Consultant Date

SECTION 19: INSURANCE PREMIUM PAYMENT BENEFIT

Clients may lose private insurance coverage due to a change in family circumstances (loss of job, etc.) or have difficulty continuing to pay the insurance premium. **When a CSHCS client loses or obtains access to private health insurance coverage, Medicare Part B, or Medicare Part D, CSHCS may assist in paying toward the cost of the premium. It must be deemed cost effective for CSHCS, and the client/family must have a financial hardship that interferes with their ability to pay for the coverage.**

The insurance premium payment benefit allows the client to maintain health care coverage, resulting in a reduction of medical expenditures by MDCH. **The Application for Payment of Health Insurance Premiums (MSA 0725; see Appendix D)** is required to apply for the benefit. **The client/family should contact the LHD to obtain the MSA 0725 and for assistance on completing the form.**

CSHCS may consider paying the cost of the premium when there is a significant financial hardship for the family to cover either COBRA or standard health insurance, and any one of the following additional circumstances:

- the client/family has private commercial insurance through an employer or through the purchase of a personal policy; or
- the client has Medicare Part B; or
- The client has Medicare Part D; or
- the opportunity exists for health coverage under the provisions of COBRA

19.1 COBRA

The opportunity to maintain health coverage under the provisions of COBRA exists due to various qualifying events listed below:

- 18 month limit of coverage:
  - Layoff
  - Reduction of hours
  - Termination of employment
- 36 month limit of coverage:
  - Divorce
  - Employee's death
  - Legal separation
  - Child ceases to be a dependent

When the LHD becomes aware that a client/family is about to or has experienced one of the qualifying events listed above and is not able to take advantage of the opportunity due to limited resources, the LHD should initiate discussion with the client/family to determine whether referral for the insurance premium payment benefit is appropriate.

Timeliness is important when it comes to securing COBRA coverage. A family could receive a denial upon applying for the CSHCS premium payment benefit related to COBRA coverage. If the family decides to appeal the denial, it is important that COBRA time requirements are addressed. The family may have to make a COBRA payment(s) to maintain the COBRA coverage at least until the determination has been made by the State Office of Administrative Hearings and Rules (SOAHR) for the MDCH. If the SOAHR rules in favor of the family, but they have let the COBRA coverage time requirements expire, then there will be no access to COBRA for CSHCS to cover.

19.2 Medicare Part B Buy-In

CSHCS offers a Medicare Part B premium payment benefit for those clients who have Medicare coverage. A client may qualify for Medicare coverage if the client has end stage renal disease or other conditions, or has received 24 consecutive months of Social Security Disability Insurance (SSDI). Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and some preventive screening services.

CSHCS requires submission of specific information for the Medicare Buy In process in addition to the Application for Insurance Premium Payment. The required information includes a copy of the client's Notice of Medicare Premium Payment Due that was sent to the family on behalf of the Medicare eligible client, the client's Medicare ID number (listed on the statement), and the client's CSHCS ID number.

CSHCS faxes the Notice of Medicare Premium Payment to the Medicare Buy In Unit. The Buy In process takes approximately 120 days to complete, and is processed retroactively back to the date Medicare Part B became effective. The Centers for Medicare and Medicaid Services (CMS) reimburses the family for any out-of pocket costs paid for premiums to maintain Medicare Part B coverage while the Buy In was in process.

19.3 Insurance Premium Payment Application Process

When the LHD becomes aware that a family is experiencing financial hardship in paying the insurance premium for a CSHCS client, the LHD should discuss the insurance premium payment program with the family.

The following documentation is required to apply for CSHCS payment of insurance premiums:

- **A completed Application for Payment of Health Insurance Premiums (MSA 0725).**
- **Copy of the billing statement from the insurance carrier or a statement from the employer verifying the cost of the insurance premium.**
- **Copies of the Explanation of Benefit (EOB) statements or expenditure summaries from the private health insurance carrier or Medicare.**
- **Copy of the completed COBRA election form if health insurance is to be maintained under the provisions of COBRA.**
- **Pharmacy report documenting the cost of the prescriptions and the amount paid by the private health insurance carrier or Medicare if the coverage includes a prescription benefit.**

Questions about the insurance premium payment program should be directed to the CSHCS insurance specialist (see Appendix A).

SECTION 20: OUT-OF-STATE MEDICAL CARE

When a client is outside of the State of Michigan and becomes ill due to the CSHCS qualifying condition or a related condition and seeks emergency or non-emergency medical treatment, CSHCS may cover the service after reviewing medical reports submitted by the out-of-state treating physician. The out-of-state provider(s) must complete the provider enrollment or TPA process described in the Provider Enrollment sub-section and submit a claim to MDCH. CSHCS cannot pay for medical care if the provider is unwilling to bill for the service.

CSHCS covers out-of-state emergency medical care when services are related to the qualifying diagnosis. Emergency medical care is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- **Serious jeopardy to the health of the client;**
- **Serious impairment to bodily functions; or**
- **Serious dysfunction of any bodily organ or part.**

***Non-emergency* medical care related to the qualifying diagnosis is defined as not meeting the definition of emergency medical care and is covered out-of-state only when comparable care cannot be provided within the State of Michigan and:**

- **The service is prior authorized by CSHCS;**
- **Medicare has paid part of the service and the provider is billing for the coinsurance and/or deductibles; or**
- **The service has been determined medically necessary by MDCH (either pre- or post-service) because the client's health would be endangered if he were required to travel back to Michigan for services.**

20.1 Pre-Planned Medical Services

Coverage for out-of-state care requires prior authorization by a medical consultant. The prior authorization request should include a statement from the client's approved in-state specialist explaining the reason the service needs to be provided outside of Michigan. Prior authorization requests for out-of-state services should be sent to the Program Review Division (PRD). (See Appendix B for contact information). If approved, an authorization letter is sent to the out-of-state provider. Out-of-state providers have a responsibility to follow Michigan Medicaid policies, including the provider enrollment requirements described in the Provider Enrollment section.

Some CSHCS clients who temporarily reside out-of-state (e.g. college students, military assignment, etc.) are allowed to maintain CSHCS coverage as described in the Residency section. As a requirement for maintaining CSHCS coverage while temporarily residing out-of-state, and for renewal of out-of-state provider authorizations, the CSHCS client must return to the specialty physician in Michigan at least annually. In some cases out-of-state providers may be authorized for these clients if a referral is received from the authorized in-state specialist and information about the client's temporary residence out-of-state is noted. The out-of-state provider must be approved by the CSHCS medical consultant and must be enrolled, or agree to enroll, with Michigan Medicaid. The LHD submits the request to add the out-of-state provider(s) in the same manner as other requests. If approved, an authorization letter is sent to the out-of-state provider.

20.2 Provider Enrollment

All out-of-state providers must complete the application process described below **in order to submit claims to the MDCH or the MDCH Pharmacy Benefit Manager for payment.**

All out-of-state providers must complete the application process described below in order to submit claims to the MDCH or the MDCH Pharmacy Benefit Manager for payment.

Providers (except pharmacies) must complete the Michigan Medicaid on-line enrollment process through the MDCH CHAMPS Provider Enrollment (PE) system in order to receive reimbursement for covered services. Refer to Appendix B for contact information.

Providers that choose not to enroll as a participating provider may enter into a "trading partner only" (TPA) arrangement with MDCH. The provider must complete the online enrollment process described above and notify CSHCS or the LHD of their decision to enroll as a TPA. If the LHD is aware of the provider's decision to enroll as a TPA, the LHD should forward that information to CSHCS. When CSHCS receives notification of a TPA, an indicator is set in the PE system to reflect the TPA arrangement.

Pharmacies must have a Pharmacy Provider Enrollment and Trading Partner Agreement (MSA-1626; see Appendix D) on file with the MDCH Pharmacy Benefits Manager (PBM). Refer to Appendix B for PBM contact information.

20.3 Renewal of Out-of-State Providers

Renewing out-of-state providers is a manual process. It is not possible to automatically renew out-of-state authorization letters. The LHDs receive a report listing the clients who have out-of-state providers three months prior to the month the client's CSHCS coverage ends. The LHD should develop a system to advise the CSHCS medical consultant when a new out-of-state authorization letter is needed. The LHD is required to contact families three months prior to the month CSHCS coverage ends, making this an ideal time to review the status of out-of-state providers with the family and begin the new authorization process.

20.4 Borderland Providers

Medical care provided in borderland areas is allowed without application of the Out-of-State Medical Care criteria if the provider is enrolled in the Michigan Medicaid Program. Borderland is defined as counties outside of Michigan that are contiguous to the Michigan border and the major population centers (cities) beyond the contiguous line as recognized by MDCH.

- Indiana (Fort Wayne; Counties of Elkhart, LaGrange, LaPorte, St. Joseph, and Steuben)
- Ohio (Counties of Fulton, Lucas, Williams)
- Wisconsin (Ashland, Green Bay, Rhinelander; Counties of Florence, Iron, Marinette, Forest, and Vilas)
- Minnesota (Duluth)

Borderland providers are considered in-state providers. Borderland providers who are enrolled in the Michigan Medicaid Program must adhere to the same policies as enrolled in-state providers (e.g. providers cannot bill a client/family for any difference between the provider's charges and the MDCH payment, etc.). The LHDs may request the addition of a borderland provider to the client's authorized provider file in the same manner as other in-state providers. (See Section 16).

The LHDs authorize and assist families with travel for care received in borderland areas in the same manner as for travel in-state. Refer to the Travel Assistance section for specific information.

SECTION 21: TRAVEL ASSISTANCE

As required by Public Act 131 of 2009, for dates of service on or after December 1, 2009, the benefits described in this section are only available to CSHCS clients who also have Medicaid coverage.

CSHCS reimburses for travel to assist clients in accessing and obtaining authorized specialty medical care and treatment (in-state and out-state, as appropriate) when the family's resources for the necessary travel poses a barrier to receiving care. Travel assistance is allowed for the client and one adult to accompany the client when:

- **the client is a minor, or**
- **the client has a legal guardian, or**
- **the client's medical condition requires the need for a caregiver.**

21.1 In-State Travel

Clients who have Medicaid coverage can request travel assistance from the LHD when travel assistance from DHS is unavailable. Travel must be related to the CSHCS qualifying diagnosis. If the request for travel is not related to the CSHCS qualifying diagnosis, but is a Medicaid covered service, the LHD will refer the family to the local DHS for assistance.

To be eligible and authorized for CSHCS in-state travel assistance, the client must be determined by MDCH to meet the following criteria:

- **The client has CSHCS coverage at the time of the travel;**
- **The Travel Assistance is for obtaining CSHCS specialty medical care and treatment from a CSHCS approved provider for the CSHCS medically-eligible diagnosis;**
- **The client/family lacks the financial resources to pay for all or part of the travel expenses;**
- **Other travel/financial resources are unavailable or insufficient;**
- **The mode of travel to be used is the least expensive and most appropriate mode available; and**
- **Prior approval for travel assistance has been obtained.**

Travel to borderland providers is considered the same as travel to in-state providers and follows the same requirements and rules.

Travel assistance is authorized on the Client Transportation Authorization and Invoice form (MSA 0636; Appendix D). Authorization is given for up to one month per form. Reimbursement is made according to the allowable rates established by MDCH as indicated on the MDCH website.

21.1-A In-State Travel Assistance Requests

Requests for in-state travel assistance are initiated at the LHD. The LHDs are authorized to issue travel assistance approvals, denials, and transportation invoices based on the specific criteria stated in each of the travel assistance sections.

The LHDs complete Section 1 of the Transportation Authorization and Invoice form (MSA-0636; Appendix D). When the LHD is aware that the travel assistance will involve multiple trips, the MSA-0636 form may be authorized to include all travel assistance for one calendar month. Any unusual circumstances should be documented in Section 1 (Describe reason for exception to policy). Unusual circumstances include, but are not limited to, situations where a facility bills MDCH directly. The LHD representative signs the form in Section 1 and provides a copy of the authorization form to the client/family. An additional copy may be faxed directly to the facility or provided to the client/family to give to the facility. The client/family should be instructed to take the copy(ies) of the authorization form with them to present to the facility if requested to do so. Completion of the MSA-0636 form eliminates the need for the LHD to issue a separate authorization letter to the family. Such authorization letters, if submitted with the MSA-0636 form, may cause delays in reimbursement to the family. Questions regarding the MSA-0636 form may be directed to the CSHCS Quality and Program Services Section (see Appendix A).

When the LHD is unable to provide the usual transportation assistance, the LHD may refer the family to the transportation contractor.

21.2 Medical Transportation Management (MTM) Contractor

1. MTM has been contracted to provide transportation assistance for medical treatment purposes that are not otherwise available to CSHCS clients. MTM services are not to be used to replace current transportation options as would normally be arranged through the local health department.

2. CSHCS clients with a payment agreement are eligible for in-state travel assistance.

3. Transportation assistance is limited to clients without Medicaid coverage for care related to the CSHCS qualifying diagnosis.

4. Transportation assistance needs the dually eligible Title V/Title XIX clients is to be referred to DHS. In the event DHS supported transportation is not available, transportation assistance through MTM is limited to care related to CSHCS qualifying diagnosis.

5. Transportation assistance is for the client and one accompanying adult. See #9 for Exceptions

6. Transportation for parents/guardians visiting clients during an inpatient stay is not a covered benefit. See #9 for Exceptions

7. Transportation must be arranged within 48-72 hours of appointment. Exceptions require authorization by the Care Coordinator for same day and 24 hour requests.

8. Transportation of minors without adult supervision requires authorization by the Care Coordinator and is intended for ongoing services which require client to receive services on a weekly basis i.e., Dialysis, Therapies (PT/OT/Speech), etc.

   a. Care Coordinator must obtain written permission from parent/guardian for any client under 16 years old

   b. Care Coordinator will fax copy of written permission form to MTM

NOTE: Care Coordinators may not authorize non-supervised transportation for children under the age of 12.

9. Transportation exceptions, determined appropriate by the Care Coordinator, require authorization. Examples of appropriate exceptions are as follows:

   a. Transportation of more than one adult with a client,

      1. A parent/guardian accompanying a minor child who is a parent of a CSHCS client (e.g. grandparent, minor parent and enrolled child of minor parent)

      2. There is a medical need for both parents to be with the client (e.g. training of caregivers)

   b. Transportation of a parent, the client and siblings of the client when there are child-care issues for the siblings,

   c. Transportation of the interpreter with the client and parent when there is a language barrier,

21.2-A Process for Authorization of Transportation through (MTM) Contractor

1. Families/clients are to contact their Care Coordinator to obtain authorization for transportation.

2. The Care Coordinator is to verify client CSHCS eligibility as per the criteria.

3. The Care Coordinator is to determine client eligibility for transportation assistance through MTM.

4. The Care Coordinator must give the family/client information that includes the following specifics when authorizing MTM transportation based on the current key-code (see end of this section):

   a. Authorization numbers are to be coded to specify:

      1. Month & day of authorization (for specific periods e.g. April 1 (1 day) or April 1-30 (1 month)

      2. Transportation type

      3. Length of services (e.g. 1 day vs. 1 month)

      4. Number of trips

      5. Type of trip

      6. Exceptions if any

      7. Provider code (e.g., gastroenterologist only)

   b. Ongoing services may be authorized for a time frame up to three months for services such as, but not limited to dialysis, therapies (OT/PT/Speech), weekly follow-up care, etc.

5. The Care Coordinator or the family/client calls MTM at the toll-free number to arrange transportation. See Directory for contact information.

   a. Care Coordinator is to contact MTM as appropriate to assist family/client in arranging transportation

   b. Family/client or Care Coordinator notifies MTM of the authorization code as indicated in #4

6. Care coordinator (or organization) to document all transportation authorizations on the authorization-tracking log.

7. MTM will refer families/clients without an appropriate authorization number to their LHD for assistance with transportation authorization.

   a. The LHD will determine if able to assist family with transportation based on:

      1. Availability of medical information to assist in determining eligibility,

      2. Date of service for transportation

   b. The LHD will consult with the family/client and/or the family/client's Care Coordinator as appropriate and notify regarding the status of any transportation arrangements

8. MTM will refer family/client back to the Care Coordinator that issued the authorization number when there are problems with the authorization number or other issues.

9. A Care Coordinator that has transportation issues and complaints is to direct those concerns to the contact person at CSHCS – Policy and Program Development Section.

   a. MTM is to handle transportation complaints as per their policy

   b. MTM is to track complaints and provide CSHCS with a monthly report

10. Care coordinator must assess and/or counsel users with a frequent (to be determined) "no-show" rate to determine adjustments to arrangements.

21.2-B Transportation Intake Screening Questions – Sample Document

1. Determine if the travel request is related to the CSHCS covered diagnosis e.g., "What kind of medical care is the appointment for? Who is the provider?" (determine if provider is authorized or if related to diagnosis and enrolled as a Medicaid provider and the system doesn't require the provider type to be formally authorized through CSHCS)

   a. Continue screening if client is CSHCS covered and transportation is diagnosis related

2. Explain to family/client "CSHCS offers mileage reimbursement if you drive your own car or have a friend or family member drive you to your appointment. Do you have a car or do you know someone who can drive you?"

   a. If yes, explain CSHCS mileage reimbursement through the LHD (refer to LHD if needed) and stop assessment for MTM

   b. If no, proceed with screening

3. "What kind of transportation is needed?"

   a. If usual LHD travel arrangement explain (refer to LHD if needed) and stop assessment for MTM

   b. If not usual LHD arrangement, proceed with screening

4. "What is the date & time of the appointment?"

5. "What is the doctor's name, address and phone number?"

6. Are there any special needs that the driver needs to be aware of for you/your child? (MTM makes more specific inquiry of the family/client in this area)

   a. Wheelchair

   b. Special stroller

   c. Car seat

   d. Medical needs

e. Pregnancy

f. Lifting, assistance down stairs

7. Who will be traveling with the child?

   a. Name, age & relationship of person traveling with the client

   b. Any special needs

21.3 Out-Of-State Travel

Clients who have Medicaid coverage can request travel assistance from the LHD. Travel must be related to the CSHCS qualifying diagnosis. If the request for travel is not related to the CSHCS qualifying diagnosis, but is a Medicaid covered service, the LHD will refer the family to the local DHS for assistance.

To be eligible and authorized for CSHCS out-of-state travel assistance, the client must be determined by CSHCS **to meet the following criteria:**

- **The client has CSHCS coverage at the time of the travel;**
- **Comparable medical care is not available to the client within the State of Michigan or borderland areas;**
- **The travel assistance is for obtaining CSHCS specialty medical care and treatment from a CSHCS approved provider for a CSHCS medically-eligible diagnosis(es);**
- **Prior approval for the out-of-state medical care and treatment was obtained from** CSHCS **before the travel assistance was requested;**
- **Prior approval for travel assistance has been obtained;**
- **The client/family lacks the financial resources to pay for all or part of the travel expenses;**
- **Other travel/financial resources are unavailable or insufficient; and**
- **The mode of travel to be used is the least expensive and most appropriate mode available.**

Travel assistance is authorized on the MSA 0636. Authorization is given for up to one month per form. Reimbursement is made according to the allowable rate set by MDCH as indicated on the MDCH website, for expenses affiliated with approved travel.

21.3-A Out-of-State Travel Assistance Requests

Out-of-state travel assistance requests are authorized by the CSHCS Quality & Program Services Section. Families may call the Family Phone Line for assistance with out-of-state travel requests. For out of state requests CSHCS will complete Section 1 of the MSA-0636 (see Appendix D) form. The LHD may assist the family by completing Section 1 of the form if requested, but the LHD representative should not sign the form. The unsigned form may be faxed or mailed to CSHCS Quality and Program Services for confirmation of approved out of state care and MDCH authorized signature.

Out of state travel will not be authorized prior to the client's enrollment in the CSHCS program and approval of the out-of-state care by a CSHCS medical consultant. Clients who are in the process of completing CSHCS enrollment are not eligible for out-of-state travel assistance.

21.4 Travel Reimbursement Process

Clients who are authorized for travel assistance must request reimbursement by submitting the completed MSA 0636 according to the instructions described on the form. Receipts are required for all reimbursable expenditures except mileage. Meal expenditures are not reimbursable. Requests for travel reimbursement must be received by MDCH within 90 days following the month authorized on the MSA 0636 to be considered for payment.

21.4-A Transportation

- **Actual mileage by private car to and from the health care service. Mileage is reimbursed according to the rate established by MDCH.** Mileage reimbursement rates can be accessed on the MDCH website or by clicking on: http://www.michigan.gov/documents/CSHCS_Travel_Fee_Screens_146317_7.pdf
- **Parking costs and highway, bridges, and tunnel tolls require original receipts.**
- **Bus, ferry or train fare, when it is the least expensive, most appropriate mode of transportation available and supported by original receipts.**

21.4-B Air Travel

- **Air travel must be arranged by CSHCS. The family cannot be reimbursed for airline tickets they have booked themselves, unless prior approval to purchase the tickets was obtained from** CSHCS.
- **Penalties, oxygen charges, etc. may be considered for reimbursement. Original receipts are required.**

21.4-C Lodging

- **The client must be required to stay overnight to obtain in-patient or out-patient treatment related to the CSHCS covered diagnosis, performed by a CSHCS approved provider and at a CSHCS approved medical facility in order for the family to be reimbursed for lodging.**
- **Inpatient Requirements: Reimbursement is for the accompanying adult as needed.**
- **Outpatient Requirements: Reimbursement is for the client and the accompanying adult as needed.**

MDCH reimburses lodging up to the allowable amount established by MDCH, regardless of cost. Original receipts are required. Reimbursement rates can be accessed on the MDCH website or by clicking on: http://www.michigan.gov/documents/CSHCS_Travel_Fee_Screens_146317_7.pdf

21.5 Travel Reimbursement Process

Requests for mileage and lodging are initiated at the LHD. The LHD will complete and sign Section 1 of the MSA-0636 Transportation Authorization and Invoice form (see Appendix D). The client/family must complete Section 2 of the MSA-0636 form and provide receipts if required. The LHD may assist with completion of Section 2 if requested to do so. The authorization form also serves as an invoice, which must be submitted to MDCH within 90 days of travel for reimbursement. Reimbursement is usually issued within six to eight weeks after receiving an invoice. Incomplete or incorrect information on the MSA-0636, failure to submit required receipts, or attaching additional documentation with the form (e.g. authorization letters given to the family by the LHD) may cause additional delays in the six to eight week reimbursement time frame. Families should keep a copy of the MSA-0636 for their records. The LHD should make copies for the family when requested to do so.

Travel reimbursement is not intended to cover the full cost of travel, but to provide some assistance in defraying the cost of travel for the family. A facility that bills MDCH for lodging may not consider the MDCH allowable amount as payment in full, leaving the family with a balance. The family may not request additional reimbursement from MDCH when a facility has billed directly for these services.

21.6 Travel Advances and Reconciliation

Cash advances for travel expenses may be authorized on an exception basis when a family is unable to cover the cost of travel due to dire financial circumstances, or when out of state medical care requires that a family spend a lengthy amount of time away from home (e.g. organ transplants). Families requesting assistance may contact the LHD or Family Phone Line (see Appendix A).

When a family contacts the LHD to request a travel advance, the LHD staff should ascertain that the circumstances of the family warrant such assistance, and determine the specific needs of the family (lodging and/or mileage). The LHD contacts the CSHCS Quality and Program Services Section (see Appendix A) and provides the required information for authorization. CSHCS will calculate the amount of the travel advance based on the estimated costs and complete the necessary paperwork for submission to MDCH Accounting, including MDCH authorized signature. A check will be processed and mailed to the family, usually within one week of the request. It is important to contact CSHCS as soon as possible when the need for a travel advance becomes known. The MSA-0636 form (see Appendix D) is mailed to the family.

Families receiving a travel advance must complete a process to reconcile the amount of the travel advance with actual costs incurred. The family completes Section 2 of the MSA-0636 form and submits the completed form with any required receipts to MDCH. The LHD may provide assistance in completing the form if requested. Upon completion of the reconciliation process, the family will be issued a check if the allowable amount for the expenses incurred is greater than the amount of travel advance. If the allowable amount is less than the amount of the travel advance, the family will be notified by letter of the amount of the refund that is due to MDCH.

The family must submit the MSA-0636 form for reconciliation to CSHCS within 90 days of the completion of the month or the trip, whichever occurs first; however, it is preferable that the reconciliation process occur as soon as possible. Failure to complete the reconciliation process in a timely manner may result in denial of future requests for travel advances.

21.7 Non-Emergency Medical Transportation (Non-Ambulance)

Clients may be eligible for non-emergency medical transportation (e.g., Ambu-Cab, Medi-Van, vans operated by medical facilities or public entities, taxis, etc.) when at least one of the following conditions is met. Client is:

- **Wheelchair dependent; or**
- **Bed bound; or**
- **Medically dependent on life sustaining equipment which cannot be accommodated by standard transportation; or**
- **Unable to access public or private transportation for the purpose of obtaining medical care.**

Non-emergency medical transportation must be prior approved by the local health department (LHD) on the Non-Emergent Medical Transportation Authorization and Verification form (MSA 0709). Payment is made directly to the transportation provider by MDCH. The client/family should not pay the provider directly since the client/family cannot be reimbursed.

Requests for non-emergency medical transportation must be authorized by the LHD. Authorization may be given for clients who do not have the physical limitations indicated, but are unable to access any other private or public mode of transportation for the purpose of obtaining medical care. The LHD can arrange the transportation with the provider or the family can call the provider directly. If the family makes the arrangements directly with the transportation provider, either the family or the provider contacts the LHD for authorization. When the LHD determines that the client meets the above criteria for non-emergency medical transportation, the LHD completes the Non-Emergent Medical Transportation Authorization and Verification form (MSA-0709; Appendix D) to allow the provider to be reimbursed for services. The MSA-0709 is divided into four sections as follows:

- Section 1 is completed by the LHD and contains client information and the authorizing LHD information. Upon completion of Section 1 the form may be mailed to the family, and a copy faxed to the provider if requested.

- Section 2 must be signed by the family. The LHD should explain to the family, either in person or by phone, that the transportation must be verified by the physician, clinic, or other provider or the family will be responsible for payment to the transportation provider. If the LHD is working with the family in person, the LHD should obtain the family signature in Section 2.

- Section 3 must be completed by the physician, clinic, or medical provider to verify that the client was seen on the stated date. If section 3 is not completed, the transportation provider will not be reimbursed by MDCH. The family keeps one copy for their records.

- Section 4 is completed by the transport company. The transport company sends the original authorization, an itemized invoice that includes the providers Federal Tax ID number, and a copy of the provider's W-9 if not on file with MDCH to the address stated on the form.

The transportation provider is responsible for ensuring that Sections 2, 3, and 4 of the MSA-0709 are completed correctly or payment may be delayed or denied.

Occasionally the LHD may become aware of a client who requires ongoing regular treatment (e.g. dialysis, radiation, etc.) and is unable to travel to the treatment appointments by regular methods of transportation (e.g., family does not have a vehicle). If the LHD determines that the circumstances are appropriate to authorize non-emergency transportation, the LHD completes Section 1 of the MSA-0709. For ongoing treatment, the MSA-0709 may be completed weekly or monthly according to the transportation provider's preference. Multiple trips are indicated by entering the number of trips per week and the duration (e.g. M, W, F for one week; three times weekly for one month) in the "Date" portion of Section 1. Upon completion of Section 1, the LHD proceeds as above to allow the provider to be reimbursed for services.

21.8 Non-Emergency Ambulance Transportation

Situations arise that require a client to be transported from one place to another by ambulance, but the transport is not considered an emergency. Examples include, but are not limited to:

- transportation of a client from one hospital or facility to another;

- transportation of a client from the hospital to the client's home when the client may require support services not available through the usual non-emergent transportation providers (Ambu-Cab, Medi-Van, etc.);

- transportation of a client from home to a physician's office, hospital, or other facility when the client may require support services not available through the usual non-emergent transportation providers (Ambu-Cab, Medi-Van, etc.)

The service requires a physician's order. The physician's order must include the client name and ID number, the medical necessity that requires ambulance transport, and the physician signature and NPI number. The ambulance company providing the service is responsible for maintaining documentation of the physician's order in their files.

Non-emergency ambulance transportation must be provided by a Medicaid enrolled licensed ambulance company to be reimbursed by MDCH. The service does not require a prior authorization number/letter, but the ambulance provider must be added to the client's authorized provider list in order to be reimbursed by MDCH.

The hospital social worker, hospital staff, physician, family, ambulance company, or other appropriate party usually arranges for the non-emergency ambulance transportation. The LHD can also arrange transportation if requested. When the LHD arranges non-emergency ambulance transportation, it is the responsibility of the LHD to contact a Medicaid enrolled provider as described above, and contact CSS to add the provider to the client's authorized provider list. When the LHD is contacted regarding non-emergency ambulance transportation services that have already been provided, the LHD contacts CSS to add the provider to the client's authorized provider list.

The following information should be included with any request to add an ambulance provider to a client's authorized provider list:

- Client name and CSHCS ID number
- Name of the ambulance company and NPI number if known
- The date of service
- The place the client was transported from and to
- The medical necessity documenting the need for an ambulance as stated in the physician's order
- The CSHCS qualifying diagnosis or related diagnosis
- Short summary of the situation requiring the transport

21.9 Special Transportation Coverage

An additional person, such as a donor related to the medical care of the client, may be considered for the travel assistance when approved by a CSHCS medical consultant. The treating specialist must provide CSHCS with documentation of the relationship between the client and the additional person.

21.9-A Special Transportation Requests

Situations may arise making it necessary to transport a client from one facility to another by special transportation (e.g. air ambulance). The facility or transport provider usually makes a request for special transportation directly to CSHCS.

When the LHD becomes aware of a situation requiring special transportation, it is helpful to ascertain the name of the transport team or provider. The LHD should contact the CSHCS Quality and Program Services Section (see Appendix A) for further details.

21.10 Emergency Transportation Coverage

CSHCS follows the same policies and procedures regarding emergency and special medical transportation coverage as the Medicaid Program. Coverage must be related to the CSHCS qualifying diagnosis.

MTM TRANSPORTATION AUTHORIZATION CODING

Authorization Date	Transportation Type	Term of Authorization	# of Trips Authorized	Type of Trip	Exception Codes	Provider Codes	
MM/YY	S = Sedan/Cab	1D = 1 day	01 = 1 trip	RT = Roundtrip	EM= Minor 13-15 yrs traveling alone	AL = Allergy	NP = Nephrology
(This is date the authorization is	V = Van	1W = 1 week	02 = 2 trips	OW = One way	EP= Additional minor passengers	AU = Audiology	NU = Neurosurgery
given. It is not the date of service)	W = Wheelchair accessible vehicle	2W = 2 weeks	03 = 3 trips		EA= Additional adult passenger	CA = Cardiology	OM = Oral Maxillofacial Surgery
	E = Other	3W = 3 weeks	04 = 4 trips		EI= Additional passenger-interpreter	CF = Craniofacial Surgery	ON = Oncology
		1M = 1 month	05 = 5 trips		EN= 24 hr request	CH = Chemotherapy	OP = Ophthalmology
		2M = 2 months	06 = 6 trips		ES = Same day request	CR = Cardiovascular/Thoracic	OR = Orthopedics
		3M = 3 months	07 = 7 trips		EH= Transport for hospital admission	DE = Diagnostic Evaluation	OT = Occupational Health
					ED= Transport for hospital discharge	DI = Dialysis	PO = Podiatry
			12 = 1x/week		EE= Diagnostic Evaluation	DM = Dermatology	PS = Plastic Surgery
			14 = 2x/week		EO = Other Exception	DN = Dental/Orthodontics	PT = Physical Therapy
			16 = 3x/week			ED = Endocrinology	PU = Pulmonary Medicine
			18 = 4x/week			EN = ENT/ Otolaryngology	PY = Physical Medicine
			20 = 5x/week			GA = Gastroenterology	RE = Rehab Medicine
						GS = General Surgery	RH = Rheumatology
						HE = Hematology	RD = Radiation Therapy
						IF - Infectious Disease	SC = Sickle Cell/Hematology
						IM = Immunology	ST = Speech Therapy
						MX = Multiple Providers	UR = Urology
						NE = Neurology	

Example: Authorization # : 1004S2W12RTGA Member would be given authorization code # 1004S2W12RT to give to MTM for transportation arrangements.

Example: Exception Authorization # : 1004S2W12RTEMGA Member would be given authorization code #1004S2W12RTEM to give to MTM for transportation.

MTM TRANSPORTATION AUTHORIZATION TRACKING LOG

County/Agency:

Date	Client Name	CSHCS ID#	Provider Name	Specialty	Authorization #	Care Coordinator	Exception

SECTION 22: PROVIDER PARTICIPATION WITH CSHCS

CSHCS approves hospitals, physician specialists, and clinics to diagnose and treat CSHCS clients. Other provider types reimbursed by the program include, but are not limited to, dentists, pharmacies, medical suppliers, audiologists, and hearing aid dealers. Providers who become formally or involuntarily excluded from participation in programs of Federal and State agencies are also excluded from participation in the CSHCS Program.

Providers enrolled in Medicaid/CSHCS are not required to render services to every client seeking care. Providers may accept CSHCS clients on a selective basis. When assisting a family, the LHD should ascertain the provider's willingness to accept the client as CSHCS, or advise the family to confirm the provider's acceptance of the client as CSHCS before obtaining services. Participating providers must accept payment from CSHCS as payment in full and cannot request additional payment from the client/family.

If a CSHCS client is told and understands that a provider is not willing to accept them as a CSHCS client, and the client agrees to be private pay, the provider may charge the client for services rendered. The provider should maintain written documentation of this agreement in the client's file. Similarly, if a client needs a medical service that is not covered by Medicaid/CSHCS, the client must be informed, prior to rendering the service, that the service is not covered. If the client chooses to receive the non-covered service, the provider and client must make their own payment arrangements. The provider should maintain written documentation of this agreement in the client's file.

22.1 CHAMPS On-line Provider Enrollment

Providers interested in rendering services to CSHCS clients must first be enrolled as Medicaid providers. Providers (except pharmacies) must complete the Medicaid on-line enrollment process through the CHAMPS Provider Enrollment (PE) system in order to receive reimbursement for covered services. Refer to Appendix B for contact information.

Pharmacies must have a Pharmacy Provider Enrollment and Trading Partner Agreement (MSA-1626; see Appendix D) on file with the MDCH Pharmacy Benefits Manager (PBM). Refer to Appendix B for PBM contact information.

All out-of-state providers must complete the application process described above in order to submit claims to the MDCH or the MDCH Pharmacy Benefit Manager for payment. Refer to the Out-of-State Medical Care Section, Provider Enrollment sub-section for more information.

22.2 Approved/Authorized Providers

An approved provider is not the same as an authorized provider.

- An approved provider has been subject to a review of credentials by the CSHCS medical consultants and deemed to be an appropriate provider to treat the special needs of CSHCS clients.

- An authorized provider is a provider who CSHCS has indicated on the CEN or the CHAMPS eligibility inquiry as being an appropriate provider of care for a specific client.

In addition to enrollment with the Michigan Medicaid Program, physicians and hospitals serving CSHCS clients must meet approval criteria to serve as a CSHCS specialty care provider. The approval criteria are detailed in the CSHCS Approved Providers subsection.

Physicians and hospitals that meet the approval criteria, as well as other provider types noted in the CSHCS Authorized Providers subsection, may request authorization from CSHCS to provide care to a specific CSHCS client and receive reimbursement for services rendered. Services must be related to the client's CSHCS qualifying diagnosis. Refer to the CSHCS Authorized Provider subsection for additional information.

All providers must comply with prior authorization requirements associated with specific services as described in the Medicaid Provider Manual.

22.3 CSHCS Approved Providers

22.3-A Physicians

Physicians desiring to be CSHCS approved specialty care providers must:

- **Be licensed to practice as a doctor of medicine (MD) or osteopathy (DO) by the state where the service is performed.**
- **Have successfully completed medical residency.**
- **Possess Specialty Board Certification. (Board eligible physicians in the process of completing certification requirements may be provisionally approved).**
- **Be enrolled in the Michigan Medicaid program. (Refer to the General Information for Providers Chapter of this manual for additional information.)**
- **Have clinical privileges in a CSHCS approved hospital/facility.**
- **Have documented clinical training or experience with children who have diagnoses eligible for CSHCS services. A physician not having experience treating infants and young children may be conditionally approved to supervise the care of children over 12 years of age.**

22.3-B Hospitals

Hospitals desiring to be CSHCS approved must:

- **Be approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);**
- **Be enrolled in the Michigan Medicaid program;**

Have an organized Pediatrics Unit with an average daily census of 6 or greater; and

22.4 CSHCS Authorized Providers

22.4-A Providers Requiring Authorization

The following types of providers will be reimbursed for services provided to a CSHCS client only if authorized by CSHCS to render service to that client.

- **Practitioners (including physicians, dentists, optometrists, etc.)**
- **Hospitals**
- **Clinics**
- **Hearing and Speech Centers (audiologists)**
- **Ambulance**
- **MDCH volume purchase contractors (J & B, Classic Optical, etc.)**

To initiate the authorization process, affected providers must contact the CSHCS office in the local health department (LHD) in the client's county of residence.

22.4-B Providers Not Requiring Authorization

Providers that do not need authorization to render services to a CSHCS client include pharmacies, hearing aid dealers, home health agencies, independent clinical laboratories, medical suppliers/durable medical equipment, and orthotists/prothetists. They must, however, be enrolled with the Michigan Medicaid Program. These enrolled providers may render service when ordered or prescribed by a CSHCS-authorized provider and related to the client's CSHCS qualifying diagnosis.

22.5 Verifying Provider Authorization and Diagnosis Information

Authorized provider and diagnosis information can be obtained from the Client Eligibility Notice (CEN). **The CHAMPS eligibility inquiry and/or HIPAA 270/271 transaction will also indicate if the inquiring provider NPI number is authorized to render CSHCS services to the client on that DOS. Providers receive the Benefit Plan ID of CSHCS along with one of the following messages in the eligibility response:**

- **This NPI is listed. See CSHCS guidelines.**
- **This NPI is not listed. See CSHCS guidelines.**

If the client is not CSHCS eligible, providers receive the following message:

- Recipient is not eligible for CSHCS on DOS

Refer to the CHAMPS Eligibility Inquiry subsection of this manual for detailed information about provider messages on the eligibility response.

22.6 Adding Providers to a CSHCS Client's Authorized Provider List

The LHD should be the point of contact any time a client/family desires a change to the authorized provider list. The LHD notifies CSHCS CSS of the requested change (see Appendix A) through the NOA (MSA 0730; Appendix D). A specific and valid reason for adding the provider as related to a qualifying diagnosis must be part of the request.

The provider must contact MDCH to initiate the process of enrolling as a Medicaid provider. If the provider is already enrolled as a Medicaid provider, the provider or family can contact the LHD to be authorized for a specific client.

Requests to add or change providers are forwarded to the analyst for appropriate action.

22.6-A Adding Physicians and Other Providers

When requesting to add a physician or other provider, the information submitted must include:

- provider name and specialty (if applicable)
- NPI if known
- address
- phone number
- date(s) of service
- diagnosis(es) the provider is treating.

Primary care physicians are not routinely authorized, but exceptions can be made to allow the participation of the primary care provider in a treatment plan directed by a specialist. Pediatricians (for younger children) and internists (for older teens) are preferred to family physicians because of their extended training in chronic disease and expertise with these types of cases.

Examples of conditions that primary care providers may be authorized for as part of the treatment plan include, but are not limited to:

- Infants discharged from neonatal intensive care units (NICU) with any of the following diagnoses: 765.01, 765.02, 765.03, 768.03, 769, 770.7, 770.8, or 786.09.

- Infants with cleft lip and palate who have difficulty feeding and are at risk for otitis media.

- Children in the UP or other rural areas where the primary physician is coordinating long distance with the specialists.

- Children who receive Synagis prophylaxis for RSV, or flu shots at the primary care physician's office.

- Children for whom the specialists require regular checks for weight, head circumference, or blood pressure; or for those requiring lab work, injections, or symptom monitoring between visits.
- Children who require a physical exam as a prerequisite to CSHCS covered surgery.

The primary care physician is added for the date of service only.

22.6-B Adding Hospitals

Requests to add an in-state hospital or out-of-state hospital enrolled as a Michigan Medicaid provider must include the following information:

- Client name and ID number
- Hospital name and NPI if known
- Whether the need for the hospitalization is inpatient or outpatient
- Date(s) of service
- Diagnosis that was being treated
- Short description/summary of treatment needed

CSHCS is unable to add a provider that is not enrolled with Michigan Medicaid.

22.7 Eligibility Verification

It is the provider's responsibility to verify a client's CSHCS eligibility prior to rendering service. Eligibility should be verified once each calendar month at a minimum, and preferably for each date of service (DOS). CSHCS coverage dates occasionally end midmonth (family request, client reached the age of 21, etc.)

CSHCS enrolled clients are issued a mihealth card and Client Eligibility Notice (CEN). (Refer to Paper Verification of CSHCS Enrollment Section). These documents do not guarantee CSHCS eligibility until the eligibility information is verified on the CHAMPS eligibility inquiry, HIPAA 270/271 transaction, or web-DENIS.

22.7-A Eligibility Verification System (EVS)

The CHAMPS eligibility inquiry and/or the HIPAA 270/271 transaction will indicate when a client is enrolled in CSHCS for the DOS entered in the inquiry. It will also identify the CSHCS Benefit Plan and whether the provider NPI number is authorized to render CSHCS services for the client on that DOS. Providers receive one of the following messages in the eligibility response:

This NPI is listed. See CSHCS guidelines. This message means the NPI is authorized by CSHCS to render services to this client on the specified date(s) of service. Services must be related to the client's CSHCS qualifying diagnosis.

- **This NPI is not listed. See CSHCS guidelines. This message means the NPI is not authorized to render services to a CSHCS client on the specified date(s) of service. Some providers can render services to a CSHCS client without being authorized. Refer to the Authorized Provider subsections.**

Some providers can render services to a CSHCS client without being authorized. Refer to the Authorized Provider subsections.

If the client is not enrolled in CSHCS, providers receive the following message in the eligibility response:

- Recipient is not eligible for CSHCS on DOS

The provider should request that the client present a mihealth card or CEN to access information on the CHAMPS eligibility inquiry to verify CSHCS eligibility before rendering any service. If the client does not have a mihealth card or CEN, the provider can also access eligibility information with the following additional search methods:

- Client ID number.
- Client social security number (SSN) and date of birth (DOB).
- Client name and SSN (or DOB).

The eight-digit client identification (ID) number obtained from the eligibility response must be used when billing MDCH for services rendered. For CSHCS clients who also have Medicaid coverage, providers are encouraged to check for changes of enrollment status (usually for a Medicaid Health Plan verses FFS) prior to billing MDCH if the services rendered are not related to the CSHCS qualifying diagnosis(es).

22.7-B Other Billing Contractors (Netwerkes)

In addition to the CHAMPS eligibility inquiry and HIPAA 270/271 transaction, MDCH provides eligibility information to other billing contractors (e.g. Netwerkes). Client eligibility information can be accessed by using the same search methods as described above for the CHAMPS eligibility inquiry, and providers will receive the same eligibility messages. The LHDs may not be able to tell whether a specific provider is authorized for a client through the billing contractor.

22.7-C Web-DENIS

MDCH and Blue Cross Blue Shield of Michigan (BCBSM) have collaborated to make Medicaid eligibility information available for verification through BCBSM's secure, browser-based internet site called web-DENIS. Providers, including LHDs, can verify eligibility for CSHCS, Medicaid, ABW, MOMS, and MIChild. The response can be printed for use as documentation of eligibility.

Providers who do not have access to web-DENIS can refer to the BCBSM website (see Appendix B) for sign up information, including the web-DENIS application and agreement forms. Upon receipt of the completed forms, BCBSM will assign a user ID and password.

The following instructions are provided to access eligibility data through web-DENIS:

1. Log into **web-DENIS** by going to **www.BCBSM.com**:

   a. Click on the Provider tab;
   b. Enter your user ID and password in the upper left column;
   c. Press the Enter key;
   d. Click on the **"web-DENIS"** link in the left column.

2. Click on the **"Subscriber Information"** link listed on the main menu.

3. Click on the **"Eligibility/Coverage/COB"** link.

4. Enter the Beneficiary ID in the **"Contract Number"** field (this can be left blank).

5. Click on the **"Medicaid"** radio button and then click on the **"Enter"** button.

6. Enter the Beneficiary ID (unless you previously entered it on the menu) in the **"Contract No."** field. If you do not have the Beneficiary ID, you may search using the Beneficiary Last Name, First Name, and Date of Birth (item 9).

7. Enter your provider NPI. The LHDs should use their existing provider ID number.

8. Enter the date of service that you are inquiring on. (The entire month of eligibility information will be returned to you.)

9. If you are searching by Name, you will need to fill in the "Patient First Name," "Patient Last Name" and "Patient Date of Birth."

10. Click on **"Enter"** to begin your search.

22.8 Prior Authorization

Some services for CSHCS clients may require prior authorization. CSHCS follows Medicaid policy for prior authorization requirements and processes. Complete coverage details and prior authorization requirements can be found in the Medicaid Provider Manual, in the chapter specific to the service requiring prior authorization. For questions/assistance with the prior authorization process, providers may call the Program Review Division. See Appendix B for contact information.

22.9 Provider Reimbursement

Information in this section is not specific to the LHDs but may be useful in discussions with providers.

Claims for the CSHCS clients are processed through the Medicaid Invoice Processing (IP) System. The billing rules and rates of reimbursement for services rendered by providers to CSHCS clients are the same as those established for the Medicaid Program and are available on the MDCH website (see Appendix B). Providers who are experiencing billing problems or other reimbursement issues should contact Provider Inquiry for assistance (see Appendix B). A protocol when assisting providers follows this section.

Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to CSHCS clients. MDCH is considered the payer of last resort.

The term "other insurance" refers to an insurance plan or carrier (e.g., individual, group, employer related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a client's medical coverage. The term is used to mean any payment source, other than MDCH, that has a financial obligation for health care coverage. Providers must utilize other payment sources to their fullest extent prior to filing a claim with the MDCH. Billing MDCH prior to exhausting other insurance resources may be considered fraud if the provider is aware that the client had other insurance coverage for the services rendered.

MDCH payment liability for clients with private commercial health insurance is the lesser of the client's liability (including coinsurance, co-payments, or deductibles), the provider's charge, or the maximum Medicaid fee screen, minus the insurance payments and contractual adjustments. (A contractual adjustment is an amount established in an agreement with a third-party payer to accept payment for less than the amount of charges). CSHCS clients must use the highest level of benefit available through their other insurance carrier (refer to the Other Insurance subsection of this Manual).

Providers may enter into agreements with other insurers to accept payment that is less than their usual and customary fees. Known as "Preferred Provider" or "Participating Provider" Agreements, these arrangements are considered payment-in-full for services rendered. Neither the client nor MDCH has any financial liability in these situations.

Providers must secure response(s) from other insurances (e.g., explanation of benefits, denials) prior to billing MDCH except for fixed co-pay amounts or payments for non-covered services. In these cases, providers must have the Explanation of Benefits (EOB) documentation in the client's file. When billing, this documentation must be included with the claim.

If payments are made by another insurance carrier, the amount paid, whether it is paid to the provider or the client, must be reflected on the claim. It is the provider's responsibility to obtain the payment from the client if the other insurance pays the client directly. It is acceptable to bill the client in this situation. Providers may not bill a CSHCS client unless the client is the policyholder of the other insurance. Failure to repay, return, or reimburse MDCH may be construed as fraud under the Medicaid False Claim Act if the provider has received payment from a third party resource after MDCH has made a payment.

MDCH cannot reimburse families for payments made to providers.

22.10 Provider Billing Problem Call Protocol

Inform caller that we are trying to collect information that will help DCH to improve services rendered through the Provider Inquiry Line. We are not to intervene directly until the caller has attempted to resolve their problem through the Provider Inquiry Line. We will be glad to assist if the problem continues and they are able to provide us with the information indicated below.

1) Ask if Provider called the Provider Inquiry Line

   a. If no, instruct Provider to:

      i. call 1-800-292-2550, and document the name of Provider Inquiry call staff with whom the provider spoke and the date called. (They may also contact the Provider Inquiry mailbox at ProviderSupport@michigan.gov)

      ii. if not satisfied with information/assistance ask for the Provider Inquiry call staff supervisor (and document name, date and general content of the conversation)

      iii. if still not satisfied call CSHCS with the names, dates and other collected information and ask for billing assistance.

   b. If yes, ask for the name of Provider Inquiry call staff who informed/assisted the provider:

      i. if they do not know the Provider Inquiry call staff name, instruct the Provider to call Provider Inquiry back and use the instructions given above for “a”.

      ii. if they know the name of the Provider Inquiry call staff but did not speak with the supervisor have them call and ask for the supervisor (document) same as “a ii” above.

      if they know the name of the Provider Inquiry call staff and the supervisor then forward the call to CSHCS Policy and Program Development Section for billing assistance.

SECTION 23: CSHCS COORDINATION WITH OTHER HEALTH CARE COVERAGE

Clients may have coverage through CSHCS and another program simultaneously.

23.1 Medicaid

Clients may have both Medicaid and CSHCS coverage. For services not covered by CSHCS and covered by Medicaid (primary care, other specialty services, etc.), the client must comply with Medicaid requirements.

23.2 MIChild

Clients may have both MIChild and CSHCS coverage. CSHCS clients who also have MIChild coverage must enroll in the Blue Cross/Blue Shield (BCBS) MIChild plan. **For services not covered by CSHCS and covered by MIChild, the client must comply with MIChild requirements. CSHCS is not considered health insurance for purposes of MIChild eligibility.**

23.3 Transitional Medical Assistance (TMA and TMA-Plus)

Clients may have both TMA and CSHCS or TMA-Plus and CSHCS coverage. For services not covered by CSHCS and covered by TMA or TMA-Plus, the client must comply with TMA and TMA-Plus requirements.

23.4 Maternity Outpatient Medical Services (MOMS)

Clients may have both MOMS and CSHCS coverage. For services not covered by CSHCS and covered by MOMS, the client must comply with MOMS requirements.

23.5 Adult Benefit Waiver (ABW)

Clients may have both Adult Benefit Waiver (ABW) and CSHCS coverage. CSHCS is not considered health coverage for purposes of ABW eligibility. For services not covered by CSHCS and covered by ABW, the client must comply with ABW requirement.

23.6 Medicare

Clients may have both Medicare and CSHCS coverage. A CSHCS client may qualify for Medicare coverage if he is age 65 or older or, has end stage renal disease or has received Social Security Disability Insurance (SSDI) for 24 months. Medicare must be billed before Medicaid or CSHCS.

Medicare consists of several parts:

Part A is hospital insurance, which covers medically necessary inpatient hospital care and some skilled nursing facility care, hospice care, and home health care.

- When a client qualifies for Medicare and has Part A, Medicare reimburses for the service.
- When a client qualifies for Medicare but does not have Part A, CSHCS reimburses for the service.

Part B is medical insurance, which covers doctor services, outpatient hospital services, durable medical equipment, some medical supplies and some pharmaceuticals.

Part C is "Medicare Advantage" (previously called "Medicare Plus Choice", which provides Medicare benefits through private health plans (HMOs).

Part D is the Medicare prescription drug benefit. Part D is available to persons who are eligible for Part A and/or enrolled in Part B. Medicare Part D affects clients who have Medicare coverage and CSHCS. It also affects clients who have Medicaid coverage.

CSHCS clients with Medicare and Medicaid coverage are required to enroll with a Prescription Drug Plan (PDP). These clients may change drug plans at any time. The effective date of the change will be the next available month based on the Medicare enrollment cut off schedule. Prescription drugs that are covered by the Medicare Part D program are not covered for clients on Medicaid and CSHCS.

CSHCS clients who have Medicare but do not have Medicaid may choose to enroll or not enroll in a PDP. If a client chooses to enroll in a PDP, and does not have Medicaid, they can not change PDPs until open enrollment in November-December of each year. Part D information must be updated in the TPL database in the same manner as other private insurance.

CSHCS clients, who have Medicare (with or without Medicaid coverage) should not be enrolled in a PDP and a private insurance company with "creditable coverage" at the same time.

Medicare must be billed before Medicaid or CSHCS. Other covered services under CSHCS and Medicaid such as physician, medical equipment, therapies, etc., are not affected by Medicare Part D.

CSHCS clients or CSHCS/Medicaid clients who are enrolled in a PDP may receive assistance from CSHCS with co-payments and deductibles. Any client who needs assistance with their Medicare Part D co-payment or deductible can contact the Policy and Program Development Section for assistance (see Appendix A).

23.7 Other Insurance

Clients may have both CSHCS and other health insurance coverage. Clients must follow the rules of the other health insurance carrier including, but not limited to: prior authorization for services; utilization of the health insurance carrier's network providers, and referrals. Coordination of Benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevention of duplicate payments. CSHCS is the payer of last resort; all third party resources must be utilized first. MDCH will not pay for services that are covered by private health insurance. If the client's health insurance carrier rejects a claim due to the inappropriate utilization of the insurance or failure to follow the rules of the other insurance carrier, MDCH will not reimburse for the services.

When the other insurance coverage has a multi-tiered benefit level, clients are required to use the highest level of benefit available. MDCH has no liability for payment when the highest level of benefit is not used.

> Example: Client belongs to a PPO. The PPO allows the client to use both in-network or out-of-network providers without authorization. The PPO pays in-network providers at 80%, and out-of network providers at 50%. The client must use the in-network provider (highest level of benefit).

If the other insurance plan does not have an appropriate in-network provider available to serve the client, or if other extenuating circumstances exist (e.g.; continuity of care, etc.) it is the responsibility of the client/family to obtain agreement from the other insurance carrier to pay the provider at the in-network rate. If the other insurance denies the request, the client/family should pursue the other insurance carrier's appeal process.

Clients/families who do not use the highest level of benefit available through their other insurance are responsible for payment to the provider. If a provider submits a claim to MDCH and is paid in error, and the MDCH payment is recovered from the provider at a later date, the provider can bill the client/family for the full amount.

When the LHD becomes aware that a client has a change in other insurance coverage, the CSHCS Request to Add and/or Terminate Other Insurance form (DCH-0079; Appendix D) must be completed. Include a copy of the insurance card (front and back) with the request. Requests to terminate other insurance should include documentation of the termination date (termination letter, cancellation notice, COBRA letter, etc.). The completed form, copy of the insurance card, and any additional documentation may be mailed, faxed, or e-mailed directly to MDCH Revenue and Reimbursement (see Appendix B). If the information received is incomplete or not readable, the LHD may be contacted for additional information. Once the information has been verified by MDCH, it is entered on the MDCH database. Clients with other insurance may have co-payments, co-insurance, or deductibles that MDCH may be able to assist with.

- Co-payment is a fixed amount that is paid for a service (e.g., $10 for generic prescriptions; $25 for brand name prescriptions)
- Co-insurance is cost sharing between the client and the insurance carrier, usually expressed as a percentage of charge for a service (e.g., carrier pays 80%; client pays 20%)

Deductible is the amount of out-of pocket expenses that must be met by the client or family within a specified period of time before the insurance benefit will pay for a service. The deductible amount may be stated per individual or per family (e.g., $250 deductible per person; $1,000 deductible per family).

23.7-A Insurance Co-Payments

MDCH pays fixed co-payment amounts up to the Medicaid-allowable amounts (Medicaid fee screen) as long as the rules of the other insurance are followed. The provider must bill the fixed co-payment amount as the charge.

23.7-B Co-Insurance and Deductibles

CSHCS clients may have other insurance with a co-insurance amount for service or deductible. CSHCS pays the appropriate co-insurance amounts and deductibles up to the client's financial obligation to pay, or the Medicaid-allowable amount (less other insurance payments), whichever is less. If the other insurance has negotiated a rate for a service that is lower than the Medicaid allowable amount, that amount must be accepted as payment in full and Medicaid will not provide additional reimbursement.

23.7-C Services Not Covered by Another Insurance

If the other insurance does not cover a service that is a CSHCS-covered service, MDCH reimburses the provider up to the Medicaid-allowable amount if all the CSHCS coverage requirements (including authorized providers, prior authorization processes, and billing rules) are followed.

23.7-D Private Insurance Mail Order Pharmacy COB Contractor (Magellan Medicaid Administration, Inc.)

If the client has other insurance coverage that includes a mandatory mail order pharmacy benefit, the mail order benefit must be utilized. If the mail order pharmacy requires a co-payment from the client, MDCH will coordinate benefits with the mail order pharmacy by paying the client's co-payment through the pharmacy COB contractor. Clients who have mandatory mail order pharmacy coverage through a provider who does not participate with MDCH should call Magellan Medicaid Administration, Inc. for assistance (see Appendix B).

The client submits the prescription order to the mail order pharmacy according to the process the mail order pharmacy requires. At the time of the order, the client must report CSHCS coverage and provide the mail order pharmacy with the CSHCS client ID number for billing purposes. The mail order pharmacy bills the MDCH pharmacy COB contractor for the co-payment amount at the point of sale. There is no out of pocket expense for the client, and the client receives the mail order prescription with no additional waiting time beyond the pharmacy's usual time frame. MDCH pays the full co-payment amount (as opposed to the Medicaid allowable amount) for prescriptions covered through a mail order pharmacy benefit. For medications that are covered by the mail order pharmacy, but require prior authorization (PA) by MDCH, PA requirements are waived as long as the mail order pharmacy is only billing for the co-payment amount. All excluded drug categories remain excluded from this benefit. Any client who receives a bill for their co-payment from a participating or non-participating mail order pharmacy provider should call Magellan Medicaid Administration, Inc. for assistance in coordinating benefits (see Appendix B).

Clients with private insurance mail order pharmacy are usually required to receive their diabetic supplies through the mail order pharmacy. The co-pay cannot be paid through the system due to the MDCH policy that diabetic supplies may only be billed by DME providers. Use the "Co-Pay coverage re: Diabetic Supplies..." protocol following this section to assist clients. Clients who still need assistance with this problem should be told to call the Family Phone Line and ask for billing assistance.

23.7-E Changes in Other Insurance Coverage

When a client has a change in other insurance coverage (new insurance coverage, termination of previous coverage, change of carrier, etc.), the LHD can complete the CSHCS Request to Add and/or Terminate Other Insurance form (DCH 0079; Appendix D). The form, along with a copy of the insurance card (front and back), should be faxed, e-mailed, or sent to MDCH Revenue & Reimbursement Third Party Liability (TPL) Section (see Appendix B).

Do not send copies of insurance cards to CSHCS with annual update information. All changes in other insurance coverage should be directed to MDCH Revenue & Reimbursement TPL Section.

Revenue & Reimbursement TPL Section verifies the information by contacting the insurance carrier, or contacting the employer, or using internet verification sites. When information has been verified it is entered on the MDCH database, which sends the information to CHAMPS.

When Revenue & Reimbursement TPL Section receives incomplete information or unreadable insurance card copies, the LHD may be contacted for additional information.

Do not send more than one notice to TPL. Send one version of the information (fax, email or hard copy). If no changes or responses within three weeks contact TPL or the CSHCS Billing Assistance Analyst.

23.8 Court-Ordered Medical Insurance

CSHCS cannot be used as court-ordered medical insurance.

23.9 Co-Pay Coverage RE: Diabetic Supplies Using A DME Provider

Effective July 1, 2010, the State of Michigan's Pharmacy Benefits Manager (PBM) has changed its name to *Magellan Medicaid Administration Inc.* The PBM was previously known as First Health Services Corporation.

Co-pays for all pharmaceuticals (including insulin) are billed to Magellan.

- Diabetic supplies are medical supplies (DME); co-pays are billed to MDCH through the claims processing system (CHAMPS)
- Supplies covered by Medicare are billed to Medicare Part B, co-pays are billed to MDCH
- NOTE: Many pharmacies are also Medicaid enrolled as DME providers.

STANDARD PRIVATE INSURANCE (PI)

1. Does the PI require the family to purchase diabetic supplies (test strips, lancets, etc.) through a mail order pharmacy, or can they use a local provider? If mail order only – go to # 7 If the family can use a local provider – continue
2. Does the PI have a specified network of providers that must be used to purchase diabetic supplies?
   - If yes, the family must comply with the network requirement and use an in-network provider that is also enrolled as a Medicaid DME provider
   - If no, the family can use any provider enrolled with Medicaid as a DME provider.

3. Does the PI cover diabetic supplies as a pharmacy or a medical supply benefit?
   - If it is a PI pharmacy benefit, the family needs to find a local pharmacy that is also enrolled with Medicaid as a DME in order to bill the co-pay to MDCH. This process is referred to as split-billing.
   - If it is a medical supply benefit, the family needs a provider that is enrolled with Medicaid as a DME provider in order to bill the co-pay to MDCH
4. Questions families should ask when they have found a potential provider:
   - Do you participate with my private insurance
   - Will you bill MDCH as a DME provider for the co-pay?
   - Do you accept MDCH payment as payment in full?

5. If a family has a PI pharmacy benefit and is unable to find a local provider who is willing to utilize the split-billing process described in #3, but has a mail order option for obtaining diabetic supplies, the family can request reimbursement of the mail order co-pays through the special CSHCS reimbursement process described in #7

MAIL ORDER PHARMACY CO-PAYS THROUGH THE CONTRACTOR: Magellan Medicaid Administration Inc.

6. Some pen needles and syringes may be covered as either pharmacy items or DME, depending on the product.
   - All pharmacy items purchased through mail order must have co-pays submitted through the Magellan process for reimbursement. Reimbursement may be made to either the mail order pharmacy or to the family.
   - If Magellan has denied any diabetic supplies, make a copy of the denial letter and see #7

MAIL ORDER PHARMACY

7. For reimbursement of co-pays for diabetic supplies purchased through mail order pharmacy that cannot be reimbursed through Magellan, the following information is required for processing:
   - Client Name and ID number
   - Name and address of the person or entity to be reimbursed (payee)
   - Payee ID (SSN) or Tax ID
   - NPI if the payee is a pharmacy
   - Copy of invoice or prescription label that shows the date of service, prescription number, NDC number, description of item, quantity, and cost

Information must be submitted to:

MDCH – CSHCS (Fax: 517-241-0796)
Lewis Cass Bldg., 6th Floor
320 S. Walnut St.
Lansing, MI 48913
Attn: CSHCS Pharmacy Claim Resolution

MAIL ORDER PHARMACY CO-PAYS THROUGH THE CONTRACTOR: MAGELLAN MEDICAID ADMINISTRATION, INC.

Some pen needles and syringes may be covered as either pharmacy items or DME, depending on the product.

- All pharmacy items purchased through mail order must have co-pays submitted through the **Magellan** process for reimbursement (Can be mail-order pharmacy or family request for reimbursement)
- If **Magellan** has denied any diabetic supplies, make a copy of denial and see # 6

MAIL ORDER PHARMACY

6. For reimbursement of co-pays for diabetic supplies purchased through mail order pharmacy that cannot be reimbursed through **Magellan**, the required information below must be submitted to:

   MDCH – CSHCS (Fax: 517-241-0796)
   Lewis Cass Bldg., 6th Floor
   320 S. Walnut St.
   Lansing, MI 48913
   Attn: CSHCS Pharmacy (PPD Section)

SECTION 24: CHILDREN WITH SPECIAL NEEDS (CSN) FUND

24.1 History and Mission

In 1944, Dr. James T. Pardee, a founder of Dow Chemical, made a generous bequest of Dow Chemical Company stock to support children with special needs. This marked the beginning of the Crippled Children's Fund, known today as the Children with Special Needs (CSN) Fund. While Dr. Pardee's gift comprises the major portion of the Fund, many other organizations, businesses, individuals, and families have contributed over the years. Today, the CSN Fund has grown to over $19 million dollars, and has helped thousands of families of children with special needs. The CSN Fund is comprised entirely of private dollars and is administered through the MDCH.

The mission of the Children with Special Needs (CSN) Fund is to provide equipment and services for children with special health care needs that no other resources provide (including state or federal programs). The CSN Fund supports unique services for special needs families/caregivers that promote optimal health and development. The CSN Fund publishes the "Children With Special Needs Fund" brochure that describes the CSN Fund and provides information to LHDs and families. Copies of this publication may be ordered by contacting the CSN Fund Executive Director (see Appendix A).

24.2 CSN Fund Eligibility Criteria

Children under age 21 who are enrolled in, or medically eligible to enroll in CSHCS are eligible to apply for assistance from the CSN Fund.

24.2-A Medical Eligibility

When a child is not currently enrolled in CSHCS, medical information from the child's specialty physician that provides details about the child's diagnosis must be submitted with the application. The CSHCS medical consultant reviews the medical information and determines whether the child is medically eligible to receive assistance from the CSN Fund.

It is not necessary to submit medical information for children who are currently enrolled in CSHCS. Children covered by the Children's Waiver (CMH) are not eligible to receive assistance from the CSN Fund.

24.2-B Income Eligibility

When a child is not currently enrolled in CSHCS, the Children With Special Needs Fund Financial Assessment form (DCH-1273; Appendix D) must be submitted with the application. CSN Fund coverage may vary according to family income. Refer to the Family Size/Income Range Chart on page 2 in the Application Procedures & Guidelines packet (DCH-1273) for details.

24.3 Covered Items

The CSN Fund may provide funding for equipment or services for eligible children. The amount the CSN Fund provides is described in the following sub-sections.

24.3-A Van Lifts and Wheelchair Tie-Downs

The CSN Fund pays up to a maximum of $6,000 for a van lift and tie-down system. The amount paid is based on family income (refer to the Family Size/Income Range Chart on the DCH-1273).

The CSN Fund will approve the lowest bid up to the maximum allowed according to the Family Size/Income Range Chart. If a family chooses a vendor who is not the lowest bidder, the preferred vendor must be indicated on the application. However, the CSN Fund only approves the amount of the lowest bid up to the maximum allowed, and the family is responsible for any remaining balance.

The CSN Fund approves a maximum of two van lifts per family. A minimum time frame of five years after the purchase of the initial van lift is required before a second lift will be considered.

Tie-downs are replaced as needed. The CSN Fund pays a maximum of $500 to replace a tie-down system.

24.3-B Home Wheelchair Ramps

The CSN Fund pays up to a maximum amount of $3,000 for the purchase and installation of home wheelchair ramps. The amount paid is based on family income (refer to the Family Size/Income Range Chart on the DCH-1273).

If a family lives in a rental unit, the owner of the dwelling must submit a statement allowing the construction of a permanent ramp to the dwelling.

A diagram of the proposed structure is required for permanent ramp requests.

All ramps funded by the CSN Fund must meet ADA requirements and any other federal, state, and local ordinances that apply.

Only one ramp will be approved per family; however, if extenuating circumstances exist, consideration may be given for a second ramp.

24.3-C Air Conditioners

The CSN Fund pays a maximum amount of $500 for a room air conditioner, regardless of income level, when deemed medically necessary for the client. If a family owns their home and is purchasing central air conditioning, the CSN Fund will contribute a maximum of $500 toward that purchase.

It is not necessary to provide quotes for room air conditioners. All such air conditioner units are purchased from one vendor and are shipped directly to the client's home; correct client address information is essential. Dimensions for the window and room where the unit will be placed must be provided. Indicate whether a standard unit (as would fit in a double-hung window) can be installed. Any special requirements or needs must be described on the application.

24.3-D Electrical Service Upgrades

The CSN Fund pays a maximum amount of $1,000 for an electrical service upgrade to accommodate medical equipment for an eligible client. Medical eligibility is determined by the CSHCS medical consultant on a case-by-case basis. Only one request for an electrical upgrade per family will be considered.

If a family does not own the home where the electrical service upgrade is to be completed, a letter from the owner of the dwelling indicating their approval for the upgrade must be included with the CSN Fund application.

24.3-E Therapeutic Tricycles and Adaptive Recreation Equipment

The CSN Fund pays a maximum of $1500 for a therapeutic tricycle or therapeutic recreation equipment. The amount paid is based on family income (refer to the Family Size/Income Range Chart on the DCH 1273).

The letter of medical necessity submitted to request the tricycle or equipment must indicate that the child has the ability to ride the tricycle or use the equipment.

When a Rifton tricycle is being requested, it is not necessary to submit any bids. Instead, a Tricycle Specification Form (DCH 1342) must be submitted.

All equipment or tricycles other than Rifton tricycles must follow CSN Fund guidelines and include three quotes with the application. When a tricycle is approved by the CSN Fund, the family will be notified of any balance they may owe according to the family size/income range chart. If a balance remains, the applicant must submit a cashiers check or money order to the CSN Fund PRIOR to the tricycle being ordered/purchased.

When requesting a room air conditioner or Rifton tricycle, please note it is not necessary to submit three bids. Please see the specific sections included in the application packet to determine what is necessary to submit.

24.4 Requests from Non-Custodial Parents

The CSN Fund considers requests from non-custodial parents; however, all guidelines still apply. If a non-custodial parent would like to apply for assistance from the CSN Fund, the custodial parent must submit a written statement of support for the request and indicate that he/she understands the CSN Fund guidelines and the limits on purchases per child. This policy is in place due to limited resources and the CSN Fund's desire to purchase equipment for the home where the child spends the majority of his/her time.

24.5 Other Requests

Requests other than those identified will be reviewed by the CSN Fund Advisory Committee.

24.6 Non-Covered Items

Items not covered by the CSN Fund include:

- Construction costs related to home modifications
- Humidifiers or air purifiers
- Generators or batteries for equipment
- Used equipment of any kind
- Repairs to equipment or vehicles
- The purchase of new or used vans or contribution toward the purchase of any vehicle
- The transfer of a van lift from one vehicle to another
- Equipment, medication, or treatments that are not approved by the Food and Drug Administration (FDA)
- Equipment or services covered through CSHCS or any other state or federally funded program (e.g., Children's Waiver, Adoption Medical Subsidy, etc.).

24.7 Application Process

The LHD provides applications and assistance to families interested in submitting a request to the CSN Fund. A family can submit an application directly to the CSN Fund if they choose. The CSN Fund does not have information regarding the availability of equipment or services in each county; therefore, it is helpful when the LHD can assist a family in locating providers in the community. It is not the role of the LHD or its representatives to determine if a request will be approved or denied, nor is it the role of the LHD to gather estimates on behalf of families for equipment and/or services.

When submitting an application to the CSN Fund, the Application (DCH-1239; Appendix D) must be completed. The application must include the following documentation

A letter of medical necessity from the child's specialty physician;

1. Quotes from three different vendors for the equipment or service being requested. If fewer than three are submitted, a statement must be included explaining the reason. All bids/quotes must come from vendors who are willing to bill MDCH for the equipment or services being requested.
2. Documentation showing that other resources have been contacted for assistance (e.g. insurance companies, professional organizations, local service organizations, charities, churches);
3. A letter from the child's family explaining the need and reason for the request.

4. The Children with Special Needs Fund Financial Assessment form (DCH-1273; Appendix D), if a child is not enrolled in CSHCS.

5. Depending on the nature of the request, additional information may be requested.

All requests must be submitted to the CSN Fund (see Appendix A). Allow four to six weeks for routine decisions to be made. If a request is urgent, indicate the urgency on the application. Requests that must be reviewed by the CSN Fund Advisory Committee require additional time for decisions to be rendered. Questions and inquiries should be directed to the CSN Fund Executive Director (see Appendix A).

24.8 Summer Camp Scholarship Program

Every fiscal year the CSN Fund determines if there will be funding available for a summer camp scholarship program. A separate application is available for the camp scholarship. Children that are enrolled in or eligible to enroll in CSHCS may apply for scholarship funds in an amount up to $500. The camp must meet CSN Fund criteria which states the camp must be licensed with the State of Michigan, operated through a university, school district or city parks and recreation program. Changes are made to the scholarship program on an annual basis. Please contact the CSN fund website or office for current information.

24.9 Notification of Decisions

When the CSN Fund approves a request, the provider of the equipment or service receives a letter from the CSN Fund Executive Director stating the specific equipment or service approved and the amount the CSN Fund will pay. A separate approval letter is mailed to the requesting family with information regarding the family's responsibility to contact the approved vendor, or with delivery information in the case of equipment already ordered on their behalf. Copies of both letters are sent to the LHD.

When the CSN Fund denies a request, the family receives a letter stating that the request has been denied and the reason for the denial. A copy of the letter is mailed to the LHD. The CSN Fund is not funded by federal or state dollars; therefore, there is no appeal process.

24.10 Reimbursement Policy

The CSN Fund will not reimburse a family or business for equipment or services already purchased or provided. The CSN Fund will not reimburse another organization or funding source that has paid for equipment or services for a client or family.

SECTION 25: LEGAL MATTERS

25.1 Appeals

CSHCS clients have the right to appeal decisions made by MDCH. Examples of decisions which may be appealed include, but are not limited to:

- Denial of Medical eligibility
- Financial participation (payment agreements)
- Denial of Services requiring prior authorization or that have been reduced, changed or terminated.

All clients have the right to request an appeal. The client is informed in writing of the action taken and the right to appeal. The appropriate appeal form is included in the written notification to the client. Appeals are usually conducted by telephone unless the client specifically requests that the appeal be conducted in person.

The LHD may assist or represent the family as requested during the appeal process. All appeal requests must be in writing and mailed to the State Office of Administrative Hearings and Rules (SOAHR) for the MDCH. If an original request for an appeal is received by the LHD, it must be faxed or mailed to the SOAHR. See Appendix B for contact information.

25.1-A Department Reviews

CSHCS clients without Medicaid coverage are entitled to appeal MDCH negative actions, and to a Department Review when they have been denied CSHCS eligibility or services, or when established CSHCS services have been reduced, changed, or terminated. The client will be notified in writing of the negative action and the right to appeal. CSHCS follows the same appeal and request for hearing policies and procedures as established by MDCH for all MDCH programs.

To request a Department Review, the client must complete and return a Request for Department Review form (DCH-0892; Appendix D) within 30 days of the date of the written notification. The Request for Department Review is usually included with the client's written notification of the change in services. The client has the right to be assisted or represented by a person of their choice during this process. Requests for Department Review must be made in writing and signed by the client or the client's representative. Department reviews are informal appeals conducted by a MDCH hearings officer. The family is informed of the decision in writing, and copies of the decision are provided to CSHCS and any party representing the family at the review. Further questions about the appeals process can be directed to the SOAHR (see Appendix B).

25.1-B Administrative Hearings

CSHCS clients who also have Medicaid coverage have a right to an Administrative Hearing when services have been denied, reduced, changed or terminated. The client will be notified in writing of the negative action and the right to appeal. The requesting client may receive an Administrative Hearing if the circumstances suggest that Medicaid reimbursement is involved in the coverage or service in question. The requesting client may receive a Department Review if the circumstances indicate that Medicaid reimbursement is in no way involved in the coverage or service in question. The SOAHR determines which hearing is appropriate once a client has requested a hearing.

To request an Administrative Hearing (also referred to as a Fair Hearing), the client must complete and return a Request for Administrative Hearing form (DCH-0092; Appendix D) within 90 days of the date of the written notification. The Request for Administrative Hearing form is usually included with the client's written notification of the change in services. The client has the right to be assisted or represented by a person of their choice during this process. Requests for Administrative Hearing must be made in writing and signed by the client or the client's representative. Administrative Hearings are formal appeals conducted by a MDCH Administrative Law Judge (ALJ). The family is informed of the decision in writing, and copies of the decision are provided to CSHCS and any party representing the family at the hearing. Further questions about the appeals process can be directed to the SOAHR (see Appendix B).

25.1-C Failure to Appear

A family or representative who is unavailable at the scheduled time of appeal will be issued a notice of Failure to Appear. Failure to Appear results in closure of the appeal process and affirmation of the MDCH decision.

25.1-D Withdrawal of Appeals

The client or a representative may withdraw the appeal request at any time during the process. To withdraw an appeal, the client or client's representative may complete Request for Withdrawal of Appeal form (DCH-0093; Appendix D) and returning it to the SOAHR. The client or client's representative may also withdraw an appeal by calling the SOAHR (see Appendix B).

25.2 Subpoenas

Occasionally, the CSHCS office in the LHD may be served with a subpoena requiring the presentation of a CSHCS client's records (medical or financial) in court.

LHDs served with subpoenas are required to:

- Record the date, time and the name of the server in the client's case file.
- Forward copies of the court order or subpoena, released bills, and any additional information to CSHCS CSS (see Appendix A). CSS is responsible for obtaining specific information from the client's case file.

- If a provider other than the LHD is served with a subpoena or court order, copies of the released information described above should be sent directly to the MDCH TPL Section. See Appendix B for contact information.
- Original documents are not to be relinquished.

25.3 Court Originated Liability Cases

A court originated liability case (formerly known as a "casualty" case) is defined as a case with the potential for recovery of MDCH expenditures made on behalf of a client seeking medical attention as the result of an auto accident, personal injury, medical malpractice, or birth trauma. MDCH funds may be recoverable from an outside responsible entity such as an insurance company, lawsuit settlement or estate.

When an application for CSHCS or conversations with potential applicant indicate or suggest that the potential client's health problem is related to an accident or birth injury (i.e., an auto insurance company listed in the insurance information section or statements made indicating the words "attorney", "adjuster", "case", "legal action"), forward a copy of the application to the MDCH TPL Section. See Appendix B for contact information.

TPL will review the information on the application and conduct appropriate follow-up with the client or family as necessary. Questions regarding court originated liability cases should be directed to TPL.

25.4 HIPAA: Confidentiality of Protected Health Information (PHI)

MDCH complies with HIPAA Privacy requirements and recognizes the concern for the confidential relationship between the provider and the client. MDCH protects this relationship by using records and information only for purposes directly related to the administration of CSHCS and/or Medicaid.

All records are of a confidential nature and should not be released, other than to a client or representative, unless the provider has a signed release from the client. The Authorization to Disclose Protected Health Information (DCH-1183) is available on the MDCH website (or see Appendix D). The Release of Information form (MSA 0838;

Appendix D) may also be used. Providers are bound to all HIPAA privacy and security requirements as federally mandated.

Occasionally the LHD may be contacted by another agency (e.g., SSI office) with a request to release client medical information. The LHD should forward all requests of this nature to CSHCS CSS for response (see Appendix A). If the LHD or provider has questions regarding the appropriateness of releasing PHI, the LHD or provider is encouraged to seek legal counsel before doing so.

SECTION 26: TRANSITION ASSISTANCE

As children enrolled in the CSHCS program age and become youth their needs begin to change. Youth must begin to look at how they will live their lives as adults and how they will receive care as adults. Families of youth who will be assisting in the transition to adulthood will also need to evaluate and address changes that must be made.

The transition into adulthood is important for youth enrolled in CSHCS because many CSHCS clients have complex needs that must be addressed when making the transition from children's services to adult services. CSHCS is evaluating the transition needs and standards for youth enrolled in the program. CSHCS is developing materials, resources, and guidance for LHDs, clients, and families to effectively make the transition to adult services and adult life.

The LHD serves an important community based role in the process of transition by providing referrals, resource information, and assistance about adult services in the state or in the local community. CSHCS is working on providing the LHDs with more effective tools with which to perform this important role. Refer to the Transition Resource Manual for the most current information and requirements regarding transitioning CSHCS clients through various life stages and needs.

SECTION 27: BEREAVEMENT

27.1 LHD Bereavement Procedure

Complete *Notification of the Death of a Client* form, which is available on the CSHCS website, www.michigan.gov/cshcs. Fax the form to the Family Center at **1-313-456-4390.** A copy of this form and a sample bereavement letter are included at the end of this section

27.2 Family Center Bereavement Procedure

Upon receipt of the *Notification of the Death of a Client* form, the Family Center will apprise the appropriate CSHCS analyst and send bereavement information to the family. There are six booklets available:

1. *Do and Don't Suggestions for the Bereaved and their Caregivers*
2. *Yourself and Grief*
3. *Helping Men in Grief*
4. *Just for Kids in Grief*
5. *Grandparents Grieve Twice*
6. *For a Friend*

27.3 CSHCS Analyst Procedure

The analyst will update the CSHCS database. Any remaining balance due on a payment agreement will be waived. CSHCS coverage will not be issued to a Medicaid-enrolled client who died prior to the CSHCS start date.

CHILDREN'S SPECIAL HEALTH CARE SERVICES
Notification of the Death of a Client

Client Information:

Date of Death: _____ (*mm/dd/yyyy)*

Last Name: _____ First Name: _____

ID#: _____ County: _____

Current Family Address:

Does the family object to receiving Bereavement Booklet(s) from the Family Center?
Yes ☐ No ☐

Analyst—Attn:

What family members are involved with this client?
(*Check all that apply*):

- Mother ☐
- Father ☐
- Siblings ☐
- Grandparents ☐
- Close Friends ☐
- Caregivers ☐

Does the family have a Payment Agreement with CSHCS? Yes ☐ No ☐

PLEASE FAX FORM:
Leah Waters, Family Center
FAX: 313-456-4390

==========

Internal Use:

☐ Bereavement letter sent to family Date: _____ Initials: _____

☐ Bereavement Booklet(s) sent to family Date: _____ Initials: _____

☐ Data entered into ORACLE Date: _____ Initials: _____

☐ DHS system updated Date: _____ Initials: _____

☐ Payment agreement cancellation notice sent Date: _____ Initials: _____

☐ Cancellation of payment agreement sent to Accounting Date: _____ Initials: _____

27.3 Bereavement Letter

<Date>

Dear Family:

On behalf of the staff of the Family Center, and volunteers in the Family Support Network of Michigan (FSN), I extend our heartfelt sympathy on the recent death of your child. As you may know, we are part of the Michigan Department of Community Health's Children's Special Health Care Services (CSHCS) Division.

We do not want you to feel alone at this difficult time. We are enclosing an envelope containing some articles about bereavement. We hope these materials will help you get through this time of loss. We also can loan you the book **Bereaved Parent**, by Harriet Sarnoff Schiff, if you wish.

If you would like any more information please feel free to contact the CSHCS Family Phone line at 1-800-359-3722.

Once again, you and your family have our deepest sympathy and please remember that we and many other parents are here to help.

Sincerely,

Mary J. Marin, Executive Director
The Family Center
Children's Special Health Care Services

Enclosures

Appendices

APPENDIX A Who to Call List

See Link listed below to CSHCS/LHD Web Page:

http://www.michigan.gov/cshcs

or directly to the LHD Web Page:

http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_35698-147678--,00.html

APPENDIX B MDCH Directory and CSHCS Directory

See Link listed below to CSHCS/LHD Web Page:

http://www.michigan.gov/cshcs

or directly to the LHD Web Page:

http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_35698-147678--,00.html

APPENDIX C Contacts at a Glance List

See Link listed below to CSHCS/LHD Web Page:

http://www.michigan.gov/cshcs

or directly to the LHD Web Page:

http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_35698-147678--,00.html

APPENDIX D Forms and Forms Reference List

Appendix D contains the listing of official forms published by MDCH. The list of forms is arranged in alpha order, then in numeric order. Samples of the forms follow the master list, and are arranged in the same order as the master list for easy location.

Forms can be downloaded from the MDCH intranet, or you may request electronic versions by e-mail by contacting the CSHCS Quality and Program Services Section.

Forms are revised on an ongoing basis. Please pay close attention to the revised date in the lower left hand corner of the form to be sure you are using the most current version. Questions about CSHCS forms should be directed to the CSHCS Quality and Program Services Section.

See Link listed below to CSHCS/LHD Web Page:

http://www.michigan.gov/cshcs

or directly to the LHD Web Page:

http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_35698-147678--,00.html

APPENDIX E CSHCS–Diagnosis Listing

CSHCS Covers over 2,600 medical diagnoses that require care by a medical or surgical subspecialist and are handicapping in nature. Diagnosis alone does not guarantee medical eligibility for CSHCS. The individual must also meet the evaluation criteria regarding the level of severity, chronicity, and the need for annual medical care and treatment by a physician subspecialist as described in the Medical Eligibility Section of the Guidance Manual.

See Link listed below to CSHCS/LHD Web Page:

http://www.michigan.gov/cshcs

or directly to the LHD Web Page:

http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_35698-147678--,00.html

APPENDIX F ACRONYM LIST

See Link listed below to CSHCS/LHD Web Page:

http://www.michigan.gov/cshcs

or directly to the LHD Web Page:

http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_35698-147678--,00.html

APPENDIX G Medicaid Provider Manual Navigation Instructions

See Link listed below to CSHCS/LHD Web Page:

http://www.michigan.gov/cshcs

or directly to the LHD Web Page:

http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_35698-147678--,00.html

The Medicaid Provider Manual contains information related to all programs administered by MDCH. It is updated on a quarterly basis and can be accessed through the MDCH website:

- Go to www.michigan.gov/medicaidproviders
- Click on "Providers"

APPENDIX H Record's Retention and Disposal Schedule

CSHCS Client Folders

Children's Special Health Care Services (CSHCS) Program files may include family/client data sheet, assessment, referrals, care plans, medical reports, narrative, physician orders, lab results, etc. Records are retained until the date of the last active eligibility period plus six (6) years.

See Link listed below:

http://www.michigan.gov/documents/hal_mhc_rms_local_gs7_106287_7.pdf

APPENDIX I CSHCS MEDICAL DIAGNOSES and POSSIBLE RELATED SPECIALTIES

See Link listed below to CSHCS/LHD Web Page:

http://www.michigan.gov/cshcs

or directly to the LHD Web Page:

http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_35698-147678--,00.html

APPENDIX J WHAT TO DO IF....

See Link listed below to CSHCS/LHD Web Page:

http://www.michigan.gov/cshcs

or directly to the LHD Web Page:

http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_35698-147678--,00.html

APPENDIX K Plan of Care (Samples)

Children's Special Health Care Services does not require a specific format for plans of care (POCs). POCs that meet the minimum requirements are available on the CSHCS Web Page.

See Link listed below to CSHCS/LHD Web Page:

http://www.michigan.gov/cshcs

APPENDIX L Reasons for Denial

See Link listed below to CSHCS/LHD Web Page:

http://www.michigan.gov/cshcs

or directly to the LHD Web Page:

http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_35698-147678--,00.html

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