MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 10-22

Distribution: All Providers

Issued: June 1, 2010

Subject: Updates to the Medicaid Provider Manual; Correction/Clarification to Bulletin MSA 10-11

Effective: As indicated

Programs Affected: Medicaid, Adult Benefits Waiver, Children's Special Health Care Services (CSHCS), Children's Waiver, Maternity Outpatient Medical Services, MIChoice Waiver, Plan First!

Updates to the Medicaid Provider Manual

The Michigan Department of Community Health (MDCH) has completed the July 2010 update of the online version of the Medicaid Provider Manual. Attachments to this bulletin describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change. Attachment II describes changes made to incorporate information from recently issued Medicaid Bulletins. These changes appear in pink in the online version of the manual. The July 2010 version of the Manual will be available on the MDCH website on July 1, 2010.

If changes were made in a chapter, a note will appear in the affected section/subsection title of that chapter's table of contents. If both technical and bulletin incorporation changes apply to the section/subsection, color coding will be limited to reflect a bulletin-related change.

Correction/Clarification to Bulletin MSA 10-11

Please note the following statement of clarification regarding Change to Pre-Admission Certification and Evaluation Review (PACER) Requirement policy as published in Bulletin MSA 10-11.

> **PACER numbers are not required for beneficiaries who have both Medicaid and CSHCS coverage when the beneficiary also has commercial health insurance that covers the hospitalization.**

Manual Maintenance

If using a CD version of the Medicaid Provider Manual, providers should retain all quarterly manual update bulletins, with their attachments, in addition to bulletins issued since the version date of the CD. Providers are encouraged to use the Michigan Medicaid Provider Manual on the MDCH website; the online version of the manual is updated on a quarterly basis. If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy and Forms, this bulletin and those referenced in this bulletin may be discarded.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
Medical Services Administration

Medicaid Provider Manual July 2010 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		References to "Oral Surgeon" were revised to read "Oral-Maxillofacial Surgeon."	Update
Throughout the Manual		References to "Administrative Tribunal" were revised to read "State Office of Administrative Hearings and Rules (SOAHR) for the Michigan Department of Community Health (MDCH)." References to "Administrative Tribunal and Appeals Division" were revised to read "Appeals Section for the Michigan Department of Community Health (MDCH)."	Update
Throughout the Manual		References to "Michigan Department of Management and Budget (DMB)" were revised to read "Michigan Department of Technology, Management & Budget (DTMB)."	Update
Throughout the Manual		References to "custom-made" were revised to read "custom-fabricated."	Update
General Information for Providers	Section 3 - Maintenance of Provider Information	Addition to bullet list in the 2nd paragraph: • Name change	Update
Beneficiary Eligibility	2.1 Benefit Plans	In the chart, for Benefit Plan INCAR-ESO, "Type" was changed from "No Benefits" to "Fee-for-Service."	Correction

* Technical Updates/Clarifications are always highlighted in yellow in the online manual.

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TECHNICAL CHANGES*

<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr>
<td>Beneficiary Eligibility</td>
<td>2.4 Scope/Coverage Codes

(new subsection; following subsections re-numbered)</td>
<td>New subsection text:

The provider must always note the beneficiary's scope/coverage code, which indicates the extent of Medicaid coverage. The scope/coverage code is two characters. The first character (numeric) indicates the scope of eligibility. This code is used for administrative purposes only.
<table>
<tr><th>Scope Code</th><th>Program</th><th>Qualifying Information</th></tr>
<tr><td>1</td><td>Medicaid</td><td>When used in conjunction with Coverage Codes D, E, F, K, P, Q, T, U, or V</td></tr>
<tr><td>2</td><td>Medicaid</td><td>When used in conjunction with Coverage Codes B, C, E, F, J, H, T, V, or 0 (zero)</td></tr>
<tr><td>3</td><td>Adult Benefits Waiver (ABW)</td><td>When used in conjunction with Coverage Codes E or G</td></tr>
<tr><td>4</td><td>Refugees and Repatriates</td><td>When used in conjunction with Coverage Code F</td></tr>
</table>
The second character (alpha) indicates the coverage available for this beneficiary. It is this part of the scope/coverage code that the provider should be aware of prior to rendering the service.
<table>
<tr><th>Coverage Code</th><th>Qualifying Information</th></tr>
<tr><td>0 (zero)</td><td>No Medicaid eligibility/coverage (refer to the Medicaid Deductible Beneficiaries Section of this chapter for additional information)</td></tr>
<tr><td>B</td><td>Qualified Medicare Beneficiary (QMB) (pays Medicare Parts A & B premiums, coinsurances, and deductibles)</td></tr>
</table>
</td>
<td>Return of information removed prematurely</td>
</tr>
</table>

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TECHNICAL CHANGES*

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(new subsection; following subsections re-numbered)</td>
<td>
<table>
<tr><th>Coverage Code</th><th>Qualifying Information</th></tr>
<tr><td>C</td><td>Specified Low Income Medicare Beneficiary (SLMB) (pays Medicare Part B premium)</td></tr>
<tr><td>D</td><td>Freedom to Work Beneficiary (full Medicaid coverage)</td></tr>
<tr><td>E</td><td>Emergency or urgent Medicaid coverage only</td></tr>
<tr><td>F</td><td>Full Medicaid coverage</td></tr>
<tr><td>G</td><td>Adult Benefits Waiver (ABW) (full ABW coverage)</td></tr>
<tr><td>H</td><td>Additional Low Income Medicare Beneficiary (ALMB) (pays Medicare Part B premium)</td></tr>
<tr><td>J</td><td>Additional Low Income Medicare Beneficiary (ALMB) (pays part of Medicare Part B premium)</td></tr>
<tr><td>K</td><td>Freedom to Work Beneficiary (full Medicaid coverage)</td></tr>
<tr><td>P</td><td>Transitional Medical Assistance-Plus (TMA-Plus) (full Medicaid coverage)</td></tr>
<tr><td>Q</td><td>Medicare Qualified Disabled Working Individual</td></tr>
<tr><td>R</td><td>Resident County Hospitalization only (administered by the local DHS office which approves hospitalization and is the payer)</td></tr>
<tr><td>T</td><td>Healthy Kids (full Medicaid coverage)</td></tr>
<tr><td>U</td><td>Transitional Medical Assistance-Plus (TMA-Plus) (emergency services only)</td></tr>
<tr><td>V</td><td>Healthy Kids (emergency services only)</td></tr>
<tr><td>Y</td><td>Family Planning Waiver (family planning services only)</td></tr>
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</td>
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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	4.3 Billing Instructions	The following sentence was added to the 2nd paragraph: Providers may bill a beneficiary for services rendered after a claim rejects for lack of Medicaid eligibility.	Clarification
Beneficiary Eligibility	9.7 Excluded Health Plan Services	The following information was added at the end of the second bullet: Beneficiaries who reside in a nursing facility are excluded from subsequent enrollment in a MHP. However, a beneficiary may occasionally be enrolled in a MHP due to administrative error. When this happens, disenrollment may be requested by either the nursing facility or MHP. For a nursing facility to request disenrollment, the facility must submit a Nursing Facility Request to Disenroll from Medicaid Health Plan form (DCH-1185) along with a copy of the Facility Admission Notice form (MSA-2565-C). The completed forms must be mailed or faxed to the MDCH Enrollment Services Section as indicated on the DCH-1185. A MHP uses the Request for Administrative Disenrollment form (MSA-2008) for disenrollment. The nursing facility or MHP must submit a disenrollment to MDCH within six months of the administrative error occurrence. Disenrollment requests that exceed six months from the date of occurrence will be retroactive to six months from receipt of the request.	Reflects previously published information.
Billing & Reimbursement for Institutional Providers	5.1 Accommodations	In the 1st paragraph, the 2nd sentence was deleted.	Obsolete information
Billing & Reimbursement for Institutional Providers	5.1.A. Private Rooms	Subsection deleted. (Following subsection re-numbered)	Obsolete information

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	8.1 Intermittent Nursing Visits/Aide Visits/ Therapies	In the 1st paragraph, the last sentence was revised to read: ... (i.e., two visits on the same day must be billed on individual lines of the same claim).	Clarification
Billing & Reimbursement for Institutional Providers	Section 9 – Private Duty Nursing Agency Claim Submission/Completion	Paragraph text was deleted.	Duplication of information found in 9.1 Direct Billing to MDCH
Billing & Reimbursement for Institutional Providers	9.1 Direct Billing to MDCH	Subsection was revised to read as follows: Providers must bill MDCH directly (either paper or electronically). When direct billing to MDCH, note the following: **Service Dates**: Each date of service must be reported on a separate claim line. **Hours/Units**: Each service line must contain the number of units of care in the "Serv. Units" for that date of service. **Prior Authorization**: The PA number listed on the Medicaid authorization letter must be recorded on the claim. **Authorization Letter**: The provider must retain the authorization letter for private duty nursing in the beneficiary's record. The authorization letter should not accompany the claim when billing.	Reorganization of information

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<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td>Billing & Reimbursement for Institutional Providers</td><td></td><td>
<table>
<tr><td>Service Dates</td><td>Each date of service must be reported on a separate claim line.</td></tr>
<tr><td>Hours/Units</td><td>Each service line must contain the number of units of care in the "Serv. Units" for that date of service.</td></tr>
<tr><td>Prior Authorization</td><td>The PA number listed on the Medicaid authorization letter must be recorded on the claim.</td></tr>
<tr><td>Plan of Care</td><td>A plan of care should not be submitted to Medicaid unless specifically requested by MDCH.</td></tr>
<tr><td>Billable Units</td><td>The total number of units reported must not exceed the total units that were authorized for that month. (PDN services are authorized in hour increments. One hour equals four 15-minute units.) Refer to the Payment in 15-Minute Increments section for additional information.)</td></tr>
<tr><td>Adjustments</td><td>Adjustments to claims are made through a total claim replacement or void/cancel process. The provider must retain the authorization letter for private duty nursing in the beneficiary's record. The authorization letter must not be mailed with the claim when billing.</td></tr>
</table>
</td><td></td></tr>
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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	9.1 Direct Billing to MDCH	**Multiple Beneficiaries Seen At Same Location**: The total Medicaid reimbursement for multiple beneficiaries is time-and-one-half for two beneficiaries. The specific procedure codes listed in the HCPCS Codes/Modifiers section must be used if an RN or LPN is caring for more than one beneficiary at the same location for which this approach to staffing has been authorized. These procedure codes must be used for each beneficiary provided care (i.e., first, second beneficiary). For example, if there is one RN caring for two children at the same location, as approved, the multiple beneficiary code must be used for both children. **Holidays**: Medicaid allows additional reimbursement for holidays. Medicaid currently recognizes the following holidays: New Year's Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving Day, and Christmas Day. A holiday begins at 12:00 am and ends at 12:00 midnight of that holiday day.	Reorganization of information
Billing & Reimbursement for Institutional Providers	9.1.C. Multiple Beneficiaries Seen at Same Location	Subsection deleted.	Relocation of information to subsection 9.1
Billing & Reimbursement for Institutional Providers	9.1.D. Holidays	Subsection deleted.	Relocation of information to subsection 9.1

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CHAPTER	SECTION	CHANGE	COMMENT
Federally Qualified Health Centers and Tribal Health Centers	4.2 Billing for Maternity Care	The following was added as the 2nd paragraph: If the FQHC elects to bill for global maternity care, all services will be reimbursed under the FFS rules.	Relocation of information
Federally Qualified Health Centers and Tribal Health Centers	4.6 Dental Claims	The 2nd paragraph was deleted.	Relocated to subsection 4.2
Hearing Aid Dealers	2.2.A. Standards of Coverage – Bilateral Hearing Loss	In the chart under "Age Under 21 Years", the 1st sentence was revised to read: Conventional analog or digital/programmable monaural or binaural hearing aid:	Correction
Hearing Services	2.3.B. Cochlear Implant Parts Replacement Maximums	In the chart: - "Pouch" was revised to read "Pouch/Carrying Case" - "Rechargeable Batteries (per set of two)" was revised to read "Rechargeable Batteries (each)" and Maximum" was revised to read "2 per year"	Clarification
Home Health	Section 2 – Home Setting	In the 1st paragraph, the 3rd sentence was removed.	Obsolete information
Hospice	5.3 Suspected Abuse/Neglect	The 1st sentence was revised to read: ... in danger of abuse, neglect, exploitation, cruelty, or other hazards, the hospice must report ...	Correction

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CHAPTER	SECTION	CHANGE	COMMENT
Hospice	5.5 Hospice Service Log	The 1st paragraph was revised to read: The hospice must complete a detailed monthly service log that indicates the services provided to the beneficiary and whether an employee or a volunteer provided them. Each service (e.g., nursing, social work, hospice aide) must be logged by the date on which it took place.	Result of comments received from CMS in a PERM audit
Hospital	3.2 Accommodations	The 1st sentence was revised to read: Medicaid covers private, semi-private, three-bed, or four-bed accommodations. The 2nd sentence was deleted.	Update; remove obsolete information
Hospital	3.2.A. Private Rooms	Subsection deleted. (Following subsection re-numbered)	Obsolete information
Medicaid Health Plans	1.1 Services Covered by Medicaid Health Plans (MHPs)	The 19th bullet point was revised to read: ▪ ... or rehabilitative nursing care (in or out of a facility) for up to 45 days The 22nd bullet point was revised to read: ▪ ... (up to 20 outpatient visits per calendar year) The following bullet points were added to the list: ▪ Tobacco cessation treatments, including pharmaceutical and behavior support ▪ Transportation for medically necessary covered services	Update
Medicaid Health Plans	1.3 Services that MHPs are Prohibited from Covering	The following bullet point was added: ▪ Services for treatment of infertility	Update

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	Section 2 - Medicaid Health Plan (addition of new section; following sections/subsections re-numbered)	New section text: The Medicaid Health Plan is responsible for restorative or rehabilitative care in a nursing facility up to 45 days in a rolling 12-month period. If nursing facility services will exceed this coverage, the health plan may initiate the disenrollment process by submitting the Request for Disenrollment Long Term Care form (MSA-2007). The nursing facility may bill Medicaid after the disenrollment is processed. Beneficiaries who reside in a nursing facility are excluded from subsequent enrollment in a MHP. However, due to administrative error, a beneficiary may occasionally be enrolled in a MHP. Disenrollment of the beneficiary from the MHP due to an administrative error may be requested by either the nursing facility or MHP. For a nursing facility to request disenrollment, the facility must submit a Nursing Facility Request to Disenroll From Medicaid Health Plan form (DCH-1185) along with a copy of the Facility Admission Notice form (MSA-2565-C). The completed forms must be mailed or faxed to the MDCH Enrollment Services Section as indicated on the DCH-1185. A MHP uses the Request for Administrative Disenrollment form (MSA-2008) for disenrollment. The nursing facility or MHP must submit a disenrollment request to MDCH within six months of the administrative error occurrence. Disenrollment requests that exceed six months from the date of occurrence will be retroactive to six months from receipt of the request.	Reflects previously published information.
Nursing Facility Coverages	4.1 Nursing Facility Eligibility	In the 1st paragraph, the 1st sentence was revised to read: There are five components that determine beneficiary eligibility and Medicaid nursing facility reimbursement: The 4th and 5th bullets were revised to read: ▪ A determination of medical/functional eligibility based upon a web-based version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) that was conducted online at the time the resident was either Medicaid eligible or Medicaid pending and conducted within the timeframes specified in the Michigan Medicaid Nursing Facility Level of Care Determination subsection of this chapter.	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
		▪ Computer-generated Freedom of Choice (FOC) form signed and dated by the beneficiary or the beneficiary's representative.	
Nursing Facility Coverages	4.1.A. Verification of Financial Medicaid Eligibility	Textbox language was revised to read: ... and the LOCD must be conducted online ONLY for Medicaid eligible or Medicaid pending beneficiaries and within the timeframes outlined in the Michigan Medicaid Nursing Facility Level of Care Determination subsection of this chapter.	Clarification
Nursing Facility Coverages	4.1.D.1. Michigan Medicaid Nursing Facility Level of Care Determination	The 1st paragraph was revised to read: ... must complete the LOCD prior to the start of Medicaid reimbursable services. The nursing facility must submit the information from any hard-copy LOCD into the LOCD's web-based version only for Medicaid eligible and Medicaid pending beneficiaries, and within the timeframes specified in the Michigan Medicaid Nursing Facility Level of Care Determination subsection of this chapter under ONLINE LOCD.	Clarification
Nursing Facility Coverages	4.1.D.1. Michigan Medicaid Nursing Facility Level of Care Determination	The 2nd and 3rd paragraphs were revised to read: The nursing facility may bill for services based upon a valid LOCD. A valid LOCD is an LOCD that was conducted within policy guidelines for a Medicaid-eligible or Medicaid-pending beneficiary. Policy guidelines are further defined in the Nursing Facility Eligibility subsection and the Verification of Financial Medicaid Eligibility subsection of this chapter. Additionally, the Medicaid-eligible or Medicaid-pending beneficiary must be determined medically/functionally eligible through the web-based version of the LOCD or the Nursing Facility LOC Exception Process criteria.	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
		A determination of Medicaid medical/functional eligibility via the hard copy or online LOCD conducted at any time in which the resident was a private pay resident is an invalid LOCD. An LOCD that was conducted online but not within policy's specified timeframes is an invalid LOCD. The nursing facility may not bill for services rendered based upon an invalid LOCD. Refer to the Michigan Medicaid Nursing Facility Level of Care Determination subsection of this chapter (under ONLINE LOCD) for timeframes in which an online LOCD must be conducted for Medicaid-eligible or Medicaid-pending beneficiaries. The nursing facility may not bill the beneficiary unless the beneficiary has been advised of the denial and elects, in advance, to pay privately for services.	
Nursing Facility Coverages	4.1.D.1. Michigan Medicaid Nursing Facility Level of Care Determination	In the 6th paragraph, the 1st sentence was revised to read: **ONLINE LOCD:** The web-based LOCD must be completed as follows:	Clarification
Nursing Facility Coverages	4.1.E. Freedom of Choice	In the 1st paragraph, the 1st and 2nd sentences were revised to read: When a Medicaid-pending or Medicaid-eligible beneficiary has qualified for services under the LOCD criteria, the computer-generated FOC form lists program options. The computer-generated form must be printed hard copy, and the beneficiary must choose and note on the form the program from which they want to receive services.	Clarification
Nursing Facility Coverages	9.8.A. Standard Equipment	The following was added after the 2nd sentence in the 1st paragraph: The nursing facility costs of these items may be reported as routine costs on the cost report. The cost of items rented for use by a resident covered under a Medicare Part A stay are not allowable routine costs and must not be reported on the cost report.	This information helps support the Nursing Facility Cost Reporting & Reimbursement Appendix on what can and cannot be claimed as routine costs on the cost report.
Nursing Facility Coverages	9.37.C. Non-Emergency Ambulance	The following information was added at the end of the paragraph: The cost of non-emergency ambulance transports not ordered by the beneficiary's physician must be identified and removed on Worksheet 1-B by the nursing facility.	Reflects information published in the Ambulance chapter.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	8.19 Patient Transportation	In the 2nd paragraph, the 1st sentence was revised to read: The nursing facility must select the most efficient and ... In the 2nd paragraph, the following was added after the 1st sentence: Whenever possible, a facility-owned vehicle should be used.	Changes reflect information published in the Ambulance and the Nursing Facility Coverages chapters.
Nursing Facility Cost Reporting & Reimbursement Appendix	8.19.A. Non-Emergency Ambulance (new subsection)	New subsection text: When a physician issues a written order for non-emergency ambulance transportation, usually due to the need for a stretcher or other emergency equipment, the ambulance provider may bill Medicaid directly and must maintain the physician's order as documentation of medical necessity. If non-emergency ambulance transport is not ordered by the beneficiary's physician, arrangements for payment must be between the facility and the ambulance provider and cannot be charged to the beneficiary, beneficiary's family, or used to offset the patient-pay amount. The cost of non-emergency ambulance transports not ordered by the beneficiary's physician must be identified and removed on Worksheet 1-B by the nursing facility.	Reflects information published in the Ambulance and the Nursing Facility Coverages chapters.
Nursing Facility Cost Reporting & Reimbursement Appendix	14.4 Administrative & General	The following items were added: Employee Background Check Fees ... Support Employee Fingerprinting Fees ... Support	Update
Pharmacy	1.1 MDCH Pharmacy Benefits Manager and Other Vendor Contractors	In the 1st paragraph, the 1st and 2nd sentences were revised to read: MDCH retains all decisions for policy, coverage, and reimbursement, and contracts with a pharmacy benefits manager (PBM).	Update
Practitioner	25.5 Maternity Care	In the chart under "Antepartum Care", the 3rd paragraph was deleted.	Obsolete information

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	2.10 Targeted Case Management Services	Under "Designated Case Manager Services", the 10th bullet was revised to read: ▪ Provide summary of provider, parent, and student health and behavioral consultation; and	per CMS request
Acronym Appendix		Deletion of: FHSC – First Health Services Corporation Addition of: MMA - Magellan Medicaid Administration, Inc.	Update in PBM name
Directory Appendix	Throughout Appendix	References to "First Health Services Corporation" were revised to read "Magellan Medicaid Administration, Inc. (MMA, Inc.)."	Update in PBM name
Directory Appendix	Beneficiary Assistance	The mailing address for MIChild/Healthy Kids/MOMS/Plan First! was revised to read: Michigan Enrolls P.O. Box 30412 Lansing, MI 48909	Update
Directory Appendix	School Based Services	Addition of: Contact/Topic: School Based Services Mailing/E-Mail/Web Address: www.michigan.gov/medicaidproviders << Billing and Reimbursement << Provider Specific Information << School Based Services Information Available/Purpose: Databases, FAQs, cost reporting & training, software information, Random Moment Time Study Results	Information
Directory Appendix	Other Health Care Services/Resources	Revisions for "MIChild": - Website for direct connection to application was added: www.healthcare4mi.com - - references to "DHS" were removed	Updates

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER(S)	SECTION	CHANGE
MSA 09-30 MSA 09-46 MSA 09-51	6/1/09 8/18/09 10/5/09	Throughout the Manual		Revisions were made as part of the ongoing process to address changes relative to the Community Health Automated Medicaid Processing System (CHAMPS). Changes included, but were not limited to, topic areas of Prior Authorization and Remittance Advice, and terms/terminology.
MSA 10-05	4/1/10	Billing & Reimbursement for Institutional Providers Hospice Hospital Nursing Facility Coverages Nursing Facility Cost Reporting & Reimbursement Appendix Acronym Appendix Directory Appendix Forms Appendix	Throughout chapters	Information regarding Complex Care Prior Authorization and Annual Pulmonary Evaluation Processes
MSA 10-09	4/1/10	School Based Services School Based Services Administrative Outreach Program Claims Development School Based Services Random Moment Time Study	Throughout chapters	Replace "9-month staff" with students" and replace related "work" with "school"

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER(S)	SECTION	CHANGE
		School Based Services	6.1.D. Cost Reconciliation and Settlement	A paragraph was added after the 2nd paragraph to clarify Cost Reconciliation.
MSA 10-10	4/1/10	Hospice	5.7.E. Private Duty Nursing (new subsection)	Addition of new subsection relative to policy for Hospice Services for Beneficiary Receiving Private Duty Nursing.
		Private Duty Nursing	2.6 Hospice Services (new subsection)	Addition of new subsection relative to policy for Hospice Services for Beneficiary Receiving Private Duty Nursing.
MSA 10-11	4/1/10	Billing & Reimbursement for Institutional Providers Hospital Practitioner	Throughout chapters	Information regarding Pre-Admission Certification and Evaluation Review (PACER) Requirement
MSA 10-12	4/1/10	Billing & Reimbursement for Institutional Providers	4.1 Authorization of Admissions and Services	Text was added and revised to address Beneficiary Change in Enrollment Status During an Episode of Care
MSA 10-13	5/1/10	Pharmacy	13.10 Coordination of Benefits	The following was inserted after the 1st sentence: Pharmacy providers should submit both the primary insurer payment amount and the beneficiary's liability (co-payment, co-insurance, and/or deductible) under the primary insurer's plan to MDCH.
MSA 10-15	5/1/10	Pharmacy	11.5 Tamper Resistant Prescriptions	In the 1st paragraph, the 1st sentence was revised to read: … fill a written prescription for an ABW or Medicaid FFS beneficiary …

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER(S)	SECTION	CHANGE
MSA 10-16	5/1/10	Medical Supplier Nursing Facility Coverages Acronym Appendix Directory Appendix Forms Appendix	Throughout chapters	Information relative to Prior Authorization and Coverage of Mobility and Custom-Fabricated Seating for Beneficiaries in the Community and in Nursing Facilities
MSA 10-17	5/1/10	Mental Health/Substance Abuse Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix Acronym Appendix	Throughout chapter	Information relative to Eligibility Criteria for the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW); New Waiver Services for the SEDW and the Children's Home and Community Based Services Waiver Program for Children with Developmental Disabilities

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Michigan Department of Community Health

Supplemental Bulletin List

April – June 2010

The following is a list of Medicaid policy bulletins that supplement the online version of the Medicaid Provider Manual. The list is updated as additional policy bulletins are issued. The updated list is posted on the MDCH website along with the Medicaid Provider Manual.

Providers affected by a bulletin should retain it until it is incorporated into the quarterly update of the online version of the manual unless instructed otherwise. Providers using a CD version of the Medicaid Provider Manual should retain all quarterly manual update bulletins, with their attachments, in addition to bulletins issued since the version date of the CD.

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
6/1/10	MSA 10-22	Updates to the Medicaid Provider Manual; Correction/Clarification to Bulletin MSA 10-11	All Providers	
6/1/10	MSA 10-21	Home Help Provider Agreement	Individual and Agency Home Help Providers	
6/1/10	MSA 10-18	Maternal Infant Health Program Policy Chapter	Maternal Infant Health Program providers, Medicaid Health Plans, Tribal Health Centers	
5/25/10	MSA 10-19	Medicaid Eligibility Reviews at Closure	Medicaid Eligibility Manual Holders	
5/1/10	MSA 10-14	Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) Code Updates for Laboratory Services and Immunizations	Practitioners, Clinical Laboratories, Tribal Health Centers, Rural Health Clinics, Federally Qualified Health Centers, Local Health Departments, Outpatient Hospitals, Medicaid Health Plans and County Health Plans	Information added to databases at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information