

Bulletin Number: MSA 12-67

Distribution: All Providers

Issued: December 1, 2012

Subject: Updates to the Medicaid Provider Manual; ICD-10 Update

Effective: January 1, 2013

Programs Affected: Medicaid, Adult Benefits Waiver, Children's Special Health Care Services, 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 January 2013 quarterly update of the Michigan Medicaid Provider Manual. The Manual is maintained on the MDCH website at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual. A compact disc (CD) version of the Manual is available to enrolled providers upon request.

The January 2013 version of the Manual does not highlight changes made during the past year (2012). However, consistent with previous quarterly manual updates, tables attached to this bulletin describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change. Subsequent changes made for the April, July, and October 2013 versions of the manual will be highlighted within the text of the on-line manual.

ICD-10 Update

The Centers for Medicare & Medicaid Services (CMS) issued a final rule on August 24, 2012 to delay the deadline for ICD-10 implementation to October 1, 2014. Beginning October 1, 2014, ICD-10-CM codes must be used on all HIPAA transactions, including outpatient claims based on dates of service and inpatient claims based on dates of discharge. ICD-10-PCS procedure codes must be used for inpatient services. It is imperative that providers continue transition efforts in order to implement the ICD-10 code sets on all HIPAA transactions.

Medical Services Administration (MSA) is continuing to promote ICD-10 awareness among Medicaid providers through Provider Outreach Awareness and Training which includes:

- ICD-10 implementation education as part of the core Medicaid educational training sessions and one-on-one provider consultations.
- Informative ICD-10 webcasts, such as ICD-10 Implementation: "Get Ready", which is available on the MDCH website at www.michigan.gov/5010icd10. Additional webcasts will be available in the future, including ICD-10 Clinical Documentation.
- State-wide ICD-10 implementation sessions. Providers should check the MDCH website regularly at www.michigan.gov/medicaidproviders (click the Medicaid Provider Training Sessions button in 'Hot Topics').

Any questions regarding ICD-10 implementation should be directed to MDCH-ICD-10@michigan.gov. Providers should continue to check the MDCH website at www.michigan.gov/5010icd10 frequently for ICD-10 updates.

Manual Maintenance

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. 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.

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 January 2013 Updates



TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		In preparation for ICD-10, references to the 9th Revision of the International Classification of Diseases (e.g., ICD-9, ICD-9-CM) have been removed or replaced with "ICD."	Future bulletins will address other policy impacted by the conversion to ICD-10, including references with specific ICD-9 diagnosis codes and billing instructions.
Throughout the Manual		Various forms of reference to the Habilitation Supports Waiver were edited for consistency in wording to read Habilitation Supports Waiver.	The name in the approved CMS waiver is Habilitation Supports Waiver.
General Information for Providers	11.2.A. Beneficiaries Excluded from Copayment Requirements	The following text was added as a 2nd paragraph: Beneficiaries excluded from Medicaid FFS copayments are also excluded from MHP copayment requirements. (Refer to the Medicaid Health Plans chapter for additional information.)	Clarification.
General Information for Providers	15.7 Clinical Records	In the 5th paragraph, the 2nd sentence was revised to read: ... required to comply with 42 CFR 483.75 and the plan of care ... The following information was added to the Clinical Documentation Requirements table located after the 5th paragraph: Column/heading: Nursing Facility/Therapies Documentation Requirement: Begin Time & End Time if Service is Time-Specific According to Procedure/Revenue Code Billed = X	Clarification. ***** A nursing facility must retain any clinical information required to comply with 42 CFR 483.75 as noted in policy. This additional check reinforces the policy.
Beneficiary Eligibility	2.1 Benefit Plans	Addition of Benefit Plan: Benefit Plan ID: DHIP Benefit Plan Name: DHS Incentive Payment	Update

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



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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans (continued)	<p>Benefit Plan Description: This benefit plan is designed to provide an incentive payment to the PIHPs to serve Medicaid-eligible children in DHS foster care and Medicaid-eligible children in Child Protective Services, Risk Category I and II.</p> <p>There are two incentive payment options:</p> <ul style="list-style-type: none"> • Incentive Payment 1 - is at least two different non-assessment mental health services were provided in the eligible month. • Incentive Payment 2 - is at least one of either home-based services or wraparound services were provided in the eligible month. <p>If a PIHP provides services to a beneficiary in a given month meeting the criteria for both Incentive Payment 1 and 2, the PIHP will only receive payment for Incentive Payment 2.</p> <p>Type: Managed Care Organization Funding Source: XIX Covered Services : MH</p> <hr/> <p>Addition of Benefit Plan: Benefit Plan ID: MME-MC Benefit Plan Name: Medicare - Medicaid Dually Eligible – Managed Care Benefit Plan Description: Managed Care Organization enrollment for beneficiaries with dual Medicare and full Medicaid eligibility. Type: Managed Care Organization Funding Source: XIX Covered Services: 1, 33, 35, 47, 48, 50, 86, 88, AL, UC</p>	Update.

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CHAPTER	SECTION	CHANGE	COMMENT										
Beneficiary Eligibility	2.3 Level of Care Codes	<p>In the 1st paragraph, the following information was revised or added to the LOC/Benefit Plan table:</p> <table border="1"> <thead> <tr> <th>LOC Code and Description</th> <th>Benefit Plan ID</th> </tr> </thead> <tbody> <tr> <td>07 - Beneficiary with Medicaid and CSHCS and enrolled in a Medicaid Health Plan</td> <td>MA (Full Medicaid), MA-MC (Medicaid Managed Care), CSHCS-MC (Children's Special Health Care Services - Managed Care), or MME-MC (Medicare-Medicaid Dually Eligible – Managed Care)</td> </tr> <tr> <td>08 - Beneficiary with Medicaid in an intermediate care facility for the mentally retarded</td> <td>ICF/MR-DD</td> </tr> <tr> <td>22 - Beneficiary with Medicaid enrolled in MIChoice</td> <td>MIChoice</td> </tr> <tr> <td>32 - Beneficiary involuntarily residing in a detention facility</td> <td>INCAR, INCAR-ABW, INCAR-ESO, INCAR-MA, INCAR-MA-E</td> </tr> </tbody> </table>	LOC Code and Description	Benefit Plan ID	07 - Beneficiary with Medicaid and CSHCS and enrolled in a Medicaid Health Plan	MA (Full Medicaid), MA-MC (Medicaid Managed Care), CSHCS-MC (Children's Special Health Care Services - Managed Care), or MME-MC (Medicare-Medicaid Dually Eligible – Managed Care)	08 - Beneficiary with Medicaid in an intermediate care facility for the mentally retarded	ICF/MR-DD	22 - Beneficiary with Medicaid enrolled in MIChoice	MIChoice	32 - Beneficiary involuntarily residing in a detention facility	INCAR, INCAR-ABW, INCAR-ESO, INCAR-MA, INCAR-MA-E	Update.
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Beneficiary Eligibility	9.9 Copayments	<p>In the 1st paragraph, text after the 1st sentence was revised and reformatted as a 2nd paragraph to read:</p> <p>For beneficiaries enrolled in an MHP, the copayment requirements and amounts may not exceed the Medicaid FFS copayments. Beneficiaries excluded from Medicaid FFS copayments are also excluded from MHP copayment requirements. A list of current copayments is available on the MDCH website. (Refer to the Directory Appendix for website information.)</p>	Clarification.										

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Coordination of Benefits	2.6.D. Medicare Part D	<p>Subsection text was revised in its entirety and now reads:</p> <p>Beneficiaries enrolled in Medicare Part A and/or Part B are eligible for Medicare Part D. Medicaid does not pay for Medicare Part D covered drugs for Medicare eligible beneficiaries.</p> <p>Medicaid will cover some of the drugs which are excluded from Part D. (Refer to the Pharmacy chapter for drug product coverage information.)</p> <p>Medicaid does not cover beneficiaries who are eligible for Part D but are not currently enrolled in a Medicare Prescription Drug Plan (PDP). Pharmacies should refer to the Pharmacy Benefits Manager (PBM) website for information on billing Medicare Part D when eligible beneficiaries have not yet enrolled in a Part D plan. (Refer to the Directory Appendix for website information.)</p> <p>All questions regarding Part D coverage should be directed to Medicare. (Refer to the Directory Appendix for contact information.)</p>	Clarification.
Coordination of Benefits	2.6.F. Medicaid Liability	<p>In the 4th paragraph, the 1st sentence was revised to read:</p> <p>If the beneficiary with Medicare coverage receives a service that is both Medicare and Medicaid covered, or receives certain services that are Medicare covered but are not Medicaid covered, MDCH may have payment liability. MDCH payment liability for beneficiaries with Medicare coverage (except Medicare Part D) is the lesser of: ...</p>	Clarification.
Billing & Reimbursement for Dental Providers	Section 13 – Julian Calendar	<p>Text after the Julian Calendar table was revised to read:</p> <p>... The next three leap years are 2016, 2020, and 2024.</p>	Update; clarification.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Dental Providers	Section 9 – Julian Calendar	<p>Example:</p> <p>Transaction Control Number (TCN) 211215010000189001 – Header TCN always ends in 000</p> <p>Position 1: "2" – DDE Web Submission</p> <p>Position 2: "1" – FFS Claim</p> <p>Positions 3-7: "12150" – YY = 12 (for 2012) + 3-digit Julian Date = 150 (May 29)</p> <p>Position 8: "1" – Original Claim</p> <p>Positions 9-15: "0000189" – Sequence Number</p> <p>Position 16-18: "001" – Line Number. Will begin with 001 for every new claim and increment by 1 for each claim line. Any replacement or voids claim, use the header TCN. Header TCN always end in 000 (211215010000189000).</p>	Update; clarification.
Billing & Reimbursement for Institutional Providers	7.3.D. Wait Time	<p>In the 2nd paragraph, the 1st sentence was revised to read:</p> <p>If more than four hours of waiting time is required, providers must request individual consideration and provide documentation.</p>	Clarification.
Billing & Reimbursement for Institutional Providers	Section 13 – Julian Calendar	<p>Text after the Julian Calendar table was revised to read:</p> <p>... The next three leap years are 2016, 2020, and 2024.</p> <p>Example:</p> <p>Transaction Control Number (TCN) 211215010000189001 – Header TCN always ends in 000</p> <p>Position 1: "2" – DDE Web Submission</p> <p>Position 2: "1" – FFS Claim</p> <p>Positions 3-7: "12150" – YY = 12 (for 2012) + 3-digit Julian Date = 150 (May 29)</p> <p>Position 8: "1" – Original Claim</p> <p>Positions 9-15: "0000189" – Sequence Number</p> <p>Position 16-18: "001" – Line Number. Will begin with 001 for every new claim and increment by 1 for each claim line. Any replacement or voids claim, use the header TCN. Header TCN always end in 000 (211215010000189000).</p>	Update; clarification.

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Billing & Reimbursement for Professionals	Section 1 – General Information	In the 2nd paragraph, addition to bullet list: <ul style="list-style-type: none"> Ambulatory Surgical Centers 	Update.
Billing & Reimbursement for Professionals	Section 9 – Julian Calendar	Text after the Julian Calendar table was revised to read: ... The next three leap years are 2016, 2020, and 2024. Example: Transaction Control Number (TCN) 211215010000189001 – Header TCN always ends in 000 Position 1: "2" – DDE Web Submission Position 2: "1" – FFS Claim Positions 3-7: "12150" – YY = 12 (for 2012) + 3-digit Julian Date = 150 (May 29) Position 8: "1" – Original Claim Positions 9-15: "0000189" – Sequence Number Position 16-18: "001" – Line Number. Will begin with 001 for every new claim and increment by 1 for each claim line. Any replacement or voids claim, use the header TCN. Header TCN always end in 000 (211215010000189000).	Update; clarification.
Adult Benefits Waiver	Section 2 – Coverage and Limitations	In the table, under Physician, Nurse Practitioner (NP), Oral-Maxillofacial Surgeon, Medical Clinic, the 6th bullet point was revised to read: <ul style="list-style-type: none"> Emergency oral surgery procedures are covered under the Medicaid physician benefit. Limited dental procedures performed by oral-maxillofacial surgeons are only covered for the relief of pain and/or infection. (The Oral-Maxillofacial Surgeon Database is available on the MDCH website. Refer to the Directory Appendix for website information.) 	Clarification.
Ambulance	1.2 Common Terms	The term and definition of "Psychiatric Emergency" was removed.	"Psychiatric Emergency" does not exist within the Ambulance chapter.
Ambulance	1.3 Ambulance Services	In the 2nd paragraph, the 1st sentence was revised to read: A physician must order all nonemergency transports, and a copy ...	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Ambulance	2.11 Waiting Time	In the 2nd paragraph, the 1st sentence was removed, and the 2nd sentence was revised to read: If more than four hours of waiting time is required, providers must ...	Clarification.
Ambulance	3.4 Nursing Facilities	In the 1st paragraph, the 2nd sentence was revised to read: This includes transportation for medical appointments, dialysis, therapies, or other treatments not available in the facility.	Removal of information not applicable to nursing facilities.
Ambulance	3.8 Out of State Nonborderland Transports	In the 2nd paragraph, the 3rd sentence was revised to read: To request authorization, the requestor must call or write the MDCH Program Review Division before services are rendered. (Refer to the Directory Appendix for contact information.)	Clarification and removal of repetitive information.
Ambulance	3.8 Out of State Nonborderland Transports (continued)	The 3rd paragraph was removed. In the 4th paragraph, the 1st sentence was revised to read: ... MDCH approves or denies the request. In the 4th paragraph, the last sentence was removed [Documentation of medical necessity (physician's order) must also be retained in the beneficiary's file to support the need for ambulance transportation.].	Clarification and removal of repetitive information.
Federally Qualified Health Centers	5.5 Prospective Payment Per Visit Rate	The subsection was given a new title: Prospective Payment Rate The 1st sentence was revised to read: An FQHC is reconciled to the prospective payment rate (PPR) determined under the PPS or the MOA. The 3rd sentence was revised to read: The PPR amount is an all-inclusive rate that covers all defined primary care services.	Update and clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Federally Qualified Health Centers	5.6 New FQHC Prospective Payment Rate	The subsection was given a new title: Prospective Payment Rate for New FQHC Sites	Clarification.
Federally Qualified Health Centers	5.8 PPS Adjustments in the Per Visit Rate	The subsection was given a new title: Adjustments to the Prospective Payment Rate The 1st and 2nd sentences were revised to read: The prospective payment rate may also be adjusted to reflect changes in the scope of services provided to Medicaid beneficiaries by an FQHC. All scope of service changes are made on a prospective basis.	Update and clarification.
Federally Qualified Health Centers	5.9 Alternative Payment Methodology	The 3rd sentence was revised to read: The MOA terms, conditions, and requirements include, but are not limited to, calculation of the prospective payment rate (PPR), PPR services, adjustment to the PPR for changes in the scope of services, denial of change in PPR, quarterly payments, and settlements.	Update and clarification.
Laboratory	Section 3 - Reimbursement Limitations	In the 4th paragraph, the following information was added to the Code/Lab Service table: 88300 - 88342 Surgical Pathology	Return of information erroneously deleted.
Medicaid Health Plans	3.2 Copayments	Subsection text was revised to read: Beneficiaries enrolled in an MHP may have different copayment requirements through the MHP than through FFS. The MHP copayment amount must be less than or equal to the Medicaid FFS copayment amount for the same service. Beneficiaries excluded from Medicaid FFS copayments are also excluded from MHP copayment requirements. A list of current copayments is available on the MDCH website. (Refer to the Directory Appendix for website information.)	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	1.7 Definition of Terms	The definition for Substance Abuse Treatment Practitioner was revised to read: An individual who has a registered MCBAP certification development plan (Development Plan – Counselor (DP-C) – approved development plan in place), is timely in its implementation, and is supervised by a Certified Clinical Supervisor – Michigan (CCS-M) or Certified Clinical Supervisor – IC & RC (CCS); or who has a registered development plan to obtain the supervisory credential (Development Plan – Supervisor (DP-S) – approved development plan in place) while completing the requirements of the plan (6000 hours).	Change made by the Michigan Certification Board for Addiction Professionals.
Mental Health/ Substance Abuse	1.7 Definition of Terms	In the definition for Substance Abuse Treatment Specialist, 1st bullet point, text after the sub-bullet points was revised to read: and who has a registered development plan leading to certification and is timely in its implementation (Development Plan – Counselor (DP-C) – approved development plan in place); or who is functioning under a time-limited exception plan approved by the substance abuse coordinating agency; or	Change made by the Michigan Certification Board for Addiction Professionals.
Mental Health/ Substance Abuse	Section 15 – Habilitation/Supports Waiver for Persons with Developmental Disabilities	The following text was added as a 7th paragraph: Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.	Clarification; update.
Mental Health/ Substance Abuse	15.1 Waiver Supports and Services	Under Community Living Supports (CLS), 5th paragraph, the last sentence was revised to read: These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent’s choice to home-school.	To clarify that CLS cannot supplant school’s responsibility for people up to age 26 since mandatory special education in Michigan is to age 26. Existing language only referenced children which was confusing for readers since adults to age 26 are also included in mandatory special education services.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	15.1 Waiver Supports and Services	Under Prevocational Services, 6th paragraph, the 1st sentence was removed. [This service must not otherwise be available to the beneficiary through the Rehabilitation Act of 1973, or Education of the Handicapped Act (P.L. 94-142).]	Update; removal of redundant information.
Mental Health/ Substance Abuse	15.1 Waiver Supports and Services	Under Private Duty Nursing, Medical Criteria III, 11th paragraph, the following text was added: For adults up to age 26 who are enrolled in school, PDN services are not intended to supplant services provided in school or other settings or to be provided during the times when the beneficiary would typically be in school but for the parent's choice to home-school.	Clarification -- to better explain to readers the boundary with mandatory special education in Michigan to age 26 as waiver services may not supplant another program or service.
Mental Health/ Substance Abuse	15.1 Waiver Supports and Services	Under Supported Employment, the 5th (last) paragraph was revised to read: Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for work activity or supported employment services provided by Michigan Rehabilitation Services (MRS). Information must be updated when MRS eligibility conditions change.	Clarification.
Mental Health/ Substance Abuse	17.3.B. Community Living Supports	In the 2nd paragraph, 1st bullet point, the 1st sentence following the sub-bullet points was revised to read: CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or state plan services, ...	Clarification that Medicaid may not supplant any service required to be provided under federal law through another program in addition to current language about state plan services.
Mental Health/ Substance Abuse	17.3.B. Community Living Supports	In the 5th (last) paragraph, the last sentence was revised to read: These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.	To make consistent with Michigan mandatory special education age up to age 26.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	17.3.J. Respite Care Services	In the 1st paragraph, the following was added as a 5th bullet point: <ul style="list-style-type: none"> Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.) 	Clarifies intent of policy.
MI Choice Waiver	11.2 Provider and Waiver Agency Appeals	The following text was inserted after the 1st paragraph: A Retrospective Review of the Michigan Medicaid Nursing Facility Level of Care Determination that results in a denial is an Adverse Action for the MI Choice Waiver agency when MDCH proposes to recover payments made for services rendered to the beneficiary for whom the Retrospective Review was conducted. If the waiver agency disagrees with the MDCH Adverse Action Notice, the agency may appeal if their written request is received by the MDCH Michigan Administrative Hearing System within 30 calendar days from the date of the MDCH Adverse Action Notice.	Clarifies those critical processes/deadlines stated in the adverse notice for MI Choice Waiver agencies appealing LOCD retrospective review.
Nursing Facility Coverages	5.2.B. Provider Appeals	Subsection text was revised to read: A Retrospective Review of the Michigan Medicaid Nursing Facility Level of Care Determination that results in a denial is an Adverse Action for the nursing facility when MDCH proposes to recover payments made for services rendered to the beneficiary for whom the Retrospective Review was conducted. If the facility disagrees with the MDCH Adverse Action Notice, the facility may appeal if their written request is received by the MDCH Michigan Administrative Hearing System within 30 calendar days from the date of the MDCH Adverse Action Notice. Information regarding the MDCH appeal process is available in the General Information for Providers chapter and on the MDCH website. (Refer to the Directory Appendix for website information.)	Clarifies those critical processes/deadlines stated in the adverse notice for Nursing Facility providers appealing LOCD retrospective reviews.

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CHAPTER	SECTION	CHANGE	COMMENT
Outpatient Therapy	5.1.F. Prescription Requirements	In the table, under "Requirements of Continued Therapy", the 2nd paragraph was removed. (The OT may request up to 12 consecutive calendar months of continued active therapy in the outpatient setting.)	Correction.
Outpatient Therapy	5.3.C. Physician Referral for Speech Therapy	In the table, under "Continued Active Treatment", the 2nd paragraph was removed. (The SLP may request up to 12 consecutive calendar months of continued active therapy in the OPH setting.)	Correction.
Pharmacy	2.2 Prescriber Identification	Text was revised to read: Pharmacy providers must provide the individual prescriber's National Provider Identifier (NPI) on the submitted claim. Refer to the Practitioner chapter for additional information.	Post-payment audits have found inaccurate Prescriber NPI reporting and this reinforces the requirements.
Pharmacy	14.14 Seasonal Influenza Vaccine	In the 2nd paragraph, the 1st sentence was revised to read: Pharmacies may submit a claim for the seasonal influenza vaccine and its administration for Fee-for-Service Medicaid, ABW, MOMS and CSHCS beneficiaries.	Further clarifies Fee-for-Service versus Medicaid Health Plan influenza coverage responsibility.
Pharmacy	Section 19 - Pharmacy Audit and Documentation	The following text was added at the end of the 2nd paragraph: Additional details pertaining to post-payment pharmacy audits can be found on the post-payment auditor's website. (Refer to the Directory Appendix for website and contact information.)	To assist pharmacy providers with audit questions and additional resources.

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CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	Section 19 - Pharmacy Audit and Documentation	<p>In the table following the 3rd paragraph, the sentence "Payment is recouped for inappropriate payments for billings found in violation of policy." was removed from the following areas:</p> <ul style="list-style-type: none"> • Changing Claim Information • Dispensing Fees • Drug(s) Returned From Nursing Facility • Hospice • Prescription Documentation • Signature Requirement • Usual & Customary (U&C) Charge 	Redundant information.
Pharmacy	Section 19 - Pharmacy Audit and Documentation	<p>In the table following the 3rd paragraph, description for Changing Claim Information, the 1st sentence was removed ("CHAMPS recognizes and denies exact duplicates.").</p>	CHAMPS does not process Fee-for-Service pharmacy claims; therefore, the information about duplicate claims being rejected is unnecessary.
Pharmacy	Section 19 - Pharmacy Audit and Documentation	<p>In the table following the 3rd paragraph, the description for Inaccurate Billing was revised in its entirety to read:</p> <p>All claim submission requirements outlined in the PBM Pharmacy Claims Processing Manual must be followed including, but not limited to, accurate Prescription Origin Code, NDC, and NDC unit of measure reporting. The Pharmacy Claims Processing Manual is available on the PBM website. (Refer to the Directory Appendix for website information.)</p>	Clarification.

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Pharmacy	Section 19 - Pharmacy Audit and Documentation	<p>In the table following the 3rd paragraph, the description for Prescription Documentation was revised as follows:</p> <p>The 1st sentence was revised to read:</p> <p>Original written prescriptions must be executed on tamper resistant prescription pads and those written prescriptions created from phone, ...</p> <p>The following text was added as a 4th bullet point:</p> <ul style="list-style-type: none"> prescriber's individual NPI <p>The following text was added as the last paragraph:</p> <p>If a prescription is created, signed, transmitted, and received electronically, all records related to that prescription must be retained electronically.</p>	Post-payment audits have found inaccurate Prescriber NPI reporting and this reinforces the requirements.
Pharmacy	Section 19 - Pharmacy Audit and Documentation	<p>In the table following the 3rd paragraph, the description for Prescriber Information was revised as follows:</p> <p>The last two sentences were removed. (Pharmacies identified through the audit process as misidentifying prescribers receive a warning letter. Continuation of incorrectly identifying prescribers results in payment being recouped for those claims.)</p>	Warning letters do not occur and accurate Prescriber NPI reporting is required under MCL 400.111b(21).
Practitioner	3.5 Developmental/ Behavioral Screening	<p>Subsection text was revised in its entirety to read:</p> <p>A psychosocial/behavioral assessment and developmental surveillance is required at each scheduled EPSDT Well Child visit from birth through adolescence as recommended by the American Academy of Pediatrics (AAP). Surveillance is accomplished by listening to caregiver concerns, asking questions about the child's history, performing an appropriate physical exam, and by observation of the child.</p>	Clarification and update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	3.5 Developmental/ Behavioral Screening (continued)	<p>The primary care physician should screen all children for behavioral and developmental concerns using a validated and standardized screening instrument as indicated by the AAP Periodicity Schedule. The provider may administer:</p> <ul style="list-style-type: none"> • Developmental Screening - Developmental screening using an objective, validated, and standardized screening instrument must be performed following the AAP Periodicity Schedule at 9, 18 and 30 (or 24) months of age, and during any other preventive pediatric health care visits when there are parent and/or provider concerns. Standardized developmental instruments that may be administered include the Parents' Evaluation of Developmental Status (PEDS), Parents' Evaluation of Developmental Status - Developmental Milestones (PEDS-DM), and Ages and Stages Questionnaire (ASQ). • Behavioral Health Screening – Behavioral Health screening is accomplished using standardized screening tools such as Ages and Stages Questionnaire - Social-Emotional (ASQ-SE), PEDS-DM, and Pediatric Symptom Checklist (PSC) with appropriate action to follow if the screening is positive. Social-emotional screening for children 0 to 5 years should be performed whenever a general development or autism specific instrument is abnormal; or at any time the clinician observes poor growth or attachment or symptoms such as excessive crying, clinginess, or fearfulness for developmental stage, or regression to earlier behavior; and at any time the family identifies psychosocial concerns. • Autism Screening – Autism screening is accomplished by administering a validated and standardized screening instrument at 18 and 24 months of age as indicated by the AAP Periodicity Schedule. The Modified Checklist for Autism in Toddlers (M-CHAT) is validated for toddlers 16 through 30 months of age. For children older than 4 years of age (mental age greater than 2 years of age), the Social Communication Questionnaire (SCQ) may be utilized. Surveillance for autism spectrum disorders is accomplished at other visits beginning at 12 months of age when there are parent and/or provider concerns and by observing for developmental lag and "red flags," such as no babbling by 12 months of age. 	Clarification and update.

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



Medicaid Provider Manual January 2013 Updates



TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	3.5 Developmental/ Behavioral Screening (continued)	<ul style="list-style-type: none"> Substance Abuse Risk Assessment – Substance Abuse risk assessment must be performed at each preventive pediatric health care visit beginning at 11 years of age, or when there are circumstances suggesting the possibility of substance abuse beginning at an earlier age. If the risk assessment is positive, appropriate action must follow as indicated by the AAP Periodicity Schedule. A validated and standardized screening instrument such as the CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) should be utilized. A maximum of three objective standardized screenings may be performed in one day for the same beneficiary by a single provider. (Refer to the Billing & Reimbursement for Professionals chapter for information regarding billing instructions.) If the screening is positive or suspected problems are observed, further evaluation must be completed by the primary care provider or the child will be referred for a prompt follow-up assessment to identify any further health needs. 	Clarification and update.
Program of All-Inclusive Care for the Elderly	3.12 Provider Appeals	<p>Subsection text was rewritten in its entirety to read:</p> <p>A Retrospective Review of the Michigan Medicaid Nursing Facility Level of Care Determination that results in a denial is an Adverse Action for PACE when MDCH proposes to recover payments made for services rendered to the beneficiary for whom the Retrospective Review was conducted. If the PACE organization disagrees with the MDCH Adverse Action Notice, the PACE organization may appeal if their written request is received by the MDCH Michigan Administrative Hearing System within 30 calendar days from the date of the MDCH Adverse Action Notice.</p> <p>Information regarding the MDCH appeal process is available in the General Information for Providers chapter and on the MDCH website. (Refer to the Directory Appendix for website information.)</p>	Clarifies critical processes/deadlines stated in the adverse notice for PACE providers appealing LOCD retrospective reviews.
Rural Health Clinics	3.2 Services Excluded from RHC Reimbursement	<p>The 2nd sentence was revised to read:</p> <p>Services not listed as primary care services are excluded from the RHC prospective payment rate (PPR).</p>	Clarification.

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Medicaid Provider Manual January 2013 Updates



TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Rural Health Clinics	4.2 Eligibility Groups Subject to PPS Methodology	Information for eligibility groups in the table was revised as follows: Medicaid Health Plan Enrollees The 5th bullet point was revised to read: <ul style="list-style-type: none"> After verification of the fair market rate by the HCRD, the difference between the RHC prospective payment rate and MHP payments are reconciled by MDCH annually. 	Clarification.
Rural Health Clinics	4.2 Eligibility Groups Subject to PPS Methodology (continued)	Healthy Kids Dental The 1st sentence was revised to read: Dental services provided to Medicaid beneficiaries enrolled in the Healthy Kids Dental program are eligible for the PPR. The 3rd sentence was revised to read: The RHC receives the difference between the PPR and the revenue received as part of the annual reconciliation.	Clarification.
Rural Health Clinics	Section 5 – Rate Setting	In the 1st paragraph, the last sentence was revised to read: For RHCs that have a fiscal year ending other than September 30, the PPR is prorated based on the number of months in each period covered by a different prospective rate.	Clarification.
Rural Health Clinics	6.2 Place of Service Requirements	In the 2nd paragraph, the 1st sentence was revised to read: RHCs may provide Medicaid covered services in settings other than the RHC office, beneficiary's home, nursing facility or domiciliary facility, but these services are not included in the PPS reimbursement methodology.	Clarification.
Rural Health Clinics	7.1.A. Increase in Scope of Service	Text was revised to read: An increase in scope of service results from the addition of a new professional staff member (i.e., contracted or employed) who is licensed to perform medical services that are approved RHC benefits that no current professional staff is licensed to perform.	Clarification.

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Medicaid Provider Manual January 2013 Updates



TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Vision	1.6 Complaint Process	In the 1st paragraph, the 2nd and 3rd sentences were removed. [The current contractor is Classic Optical Laboratories. (Refer to the Directory Appendix for contact information.)]	Repetitive information.
Vision	3.4 Ophthalmic Frames and Lenses	In the 2nd paragraph, the 4th sentence was removed. [Initial or replacement eyeglasses that do not exceed Medicaid's replacement limits do not require PA.]	Repetitive information.
Vision	3.4.A. Lenses	The 1st paragraph was revised to read: Lenses must conform to the latest edition of the <i>American National Standard Recommendations for Prescription Ophthalmic Lenses</i> . In the 2nd paragraph, the 1st sentence for "Polycarbonate Lenses" was revised to read: ... polycarbonate lenses are a Medicaid benefit when diopter criteria is met and the lenses are ...	Clarification.
Vision	3.4 B. Ophthalmic Frames	The 1st paragraph was revised to read: Frames must conform to the latest edition of the <i>American National Standard Requirements for the Dress Ophthalmic Frames</i> .	Clarification.
Acronym Appendix		Revision: PPA – Patient Pay Amount (removal of "Prospective Payment Amount") Addition: PPR - Prospective Payment Rate	General update.
Directory Appendix	Eligibility Verification	Updates for Eligibility Verification for Dates Of Service Over 12 Months - Medicare DSH Audits Only are as follows: Contact/Topic: revised to read: Medicare DSH Audits - Eligibility Verification for Dates of Service Over 12 Months for Hospital Providers Phone #/Fax #: Addition of: CHAMPS: MDCH Provider Inquiry: 800-292-2550	General update.

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Medicaid Provider Manual January 2013 Updates



TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Eligibility Verification (continued)	<p>Mailing/Email/Web Address: Addition of:</p> <p>CHAMPS: Website: www.michigan.gov/medicaidproviders >>HIPAA ICD-10 Implementation >> 5010 Information >> MDCH Companion Guides Mailing Address: MDCH/Provider Inquiry, P.O. Box 30731, Lansing, MI 48909-8231 E-mail: providersupport@michigan.gov</p> <p>Information Available/Purpose: revised to read:</p> <p>The following options are available for hospital providers to verify eligibility for DOS over 12 months for Medicare DSH audits:</p> <p>Emdeon = DSH Eligibility Verification Services (may involve a fee) MPHI = 270/271 Realtime/Batch Transactions CHAMPS = Member Eligibility Inquiry CHAMPS = 270/271 Batch Transaction</p> <p>Hospital providers that contract with clearinghouse vendors to submit/receive their DSH inquiries must have the vendor listed as one of their approved billing agents on CHAMPS (PE Subsystem).</p>	General update.
Directory Appendix	Billing Resources	<p>Update for MDCH Sanctioned Providers List: Web address for HHS Sanctioned Providers was revised to read: www.exclusions.oig.hhs.gov and www.sam.gov</p>	Change from Excluded Parties List (EPLS) to System for Award Management (SAM).

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Medicaid Provider Manual January 2013 Updates



TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Pharmacy Resources	<p>Addition of the following resource:</p> <p>Contact/Topic: Pharmacy Audits</p> <p>Phone #/Fax #: Toll free: 1-800-742-7638 Direct: 1-215-551-3838 Fax: 1-888-772-1632</p> <p>Mailing/Email/Web Address: Xerox Audit & Compliance Solutions 700 Packer Ave., Ste. 101 Philadelphia, PA 19148</p> <p>Website address: www.michiganmedicaidrxaudits.com</p> <p>Information Available/Purpose: Audit resources for pharmacy providers</p>	To assist pharmacy providers with audit questions and additional resources.

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Medicaid Provider Manual January 2013 Updates



BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 12-36	8/31/2012	Coordination of Benefits	1.2 Verification of Other Insurance	<p>Addition of 4th paragraph which reads:</p> <p>The form should be submitted prior to billing Medicaid. If known, providers should include the policy's per diem payment amount in the comments section of the form. The TPL Section will verify the information provided and update the beneficiary's CHAMPS eligibility information accordingly. The provider should bill the other resource first. Once payment has been received, the provider may bill Medicaid. The Medicaid claim must include the payment amount received from the other resource.</p>
		Coordination of Benefits	Section 2 – Categories of Other Insurance	<p>The 1st bullet point was revised to read:</p> <ul style="list-style-type: none"> ... health maintenance organizations [HMO], long-term care insurance policies and traditional indemnity policies
		Coordination of Benefits	2.1 Commercial Health Insurance	<p>Addition of an 8th paragraph which reads:</p> <p>Insurance companies should not submit checks directly to Medicaid. Rather, providers must work directly with the insurance company or the beneficiary to obtain the insurance payment. If the insurance company pays the beneficiary directly, it is the provider's responsibility to obtain the payment from the beneficiary; if the policyholder is someone other than the beneficiary, it is the provider's responsibility to obtain the payment from the policyholder.</p>
		Billing & Reimbursement for Institutional Providers	8.17 Long-Term Care Insurance	<p>The 2nd paragraph was deleted. (Information is located in the Coordination of Benefits chapter.)</p>
MSA 12-38	8/31/2012	Federally Qualified Health Centers	Table of Contents page	The burst box was removed.
		Rural Health Clinics	Table of Contents page	The burst box was removed.
		Vision	Table of Contents page	The burst box was removed.

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Medicaid Provider Manual January 2013 Updates



BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE																						
MSA 12-40	8/31/2012	Medical Supplier	1.12 Uniform Reporting of Services (new subsection)	<p>New subsection text reads:</p> <p>MDCH follows the American Medical Association's manual and guidelines for Current Procedural Terminology (CPT) numeric codes, and the Healthcare Common Procedure Coding System (HCPCS). In conjunction with the CPT/HCPCS coding systems to describe services rendered, MDCH utilizes the Medicaid National Correct Coding Initiative (NCCI) coding policies and edits as developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies.</p>																						
		Directory Appendix	Billing Resources	<p>Under "Medicaid National Correct Coding Initiative (NCCI)", the website address was revised to read:</p> <p>http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html</p>																						
MSA 12-41	8/31/2012	Dental	9.1 Coverage and Service Area Information	<p>In the 1st paragraph, the 1st sentence was revised to read:</p> <p>... in 75 counties.</p> <p>In the 2nd paragraph, the following counties were added to the chart:</p> <table border="0"> <thead> <tr> <th><u>County Name</u></th> <th><u>Number</u></th> </tr> </thead> <tbody> <tr> <td>Bay.....</td> <td>09</td> </tr> <tr> <td>Berrien</td> <td>11</td> </tr> <tr> <td>Calhoun</td> <td>13</td> </tr> <tr> <td>Cass</td> <td>14</td> </tr> <tr> <td>Grand Traverse</td> <td>28</td> </tr> <tr> <td>Jackson</td> <td>38</td> </tr> <tr> <td>Mecosta.....</td> <td>54</td> </tr> <tr> <td>Montcalm.....</td> <td>59</td> </tr> <tr> <td>Osceola</td> <td>67</td> </tr> <tr> <td>Wexford.....</td> <td>83</td> </tr> </tbody> </table>	<u>County Name</u>	<u>Number</u>	Bay.....	09	Berrien	11	Calhoun	13	Cass	14	Grand Traverse	28	Jackson	38	Mecosta.....	54	Montcalm.....	59	Osceola	67	Wexford.....	83
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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Tribal Health Center	3.2 Dental Coverages and Limitations	In the 3rd paragraph, the 1st sentence was revised to read: The Healthy Kids Dental Program is administered by a contractor in selected Michigan counties.
MSA 12-44	8/31/2012	Medicaid Provider Manual Overview	1.1 Organization	Addition to Provider/Service Specific Chapters portion of the table as follows: Chapter Title: Urgent Care Centers Affected Providers: All Providers Chapter Content: Information regarding billing, coverage, and reimbursement policies related to Urgent Care Centers.
		Billing & Reimbursement for Professionals	Section 1 – General Information	In the 2nd paragraph, addition to the bullet list: <ul style="list-style-type: none"> Urgent Care Centers
		Urgent Care Centers (new chapter)		Addition of Urgent Care Centers chapter to provide policy information.
MSA 12-46	8/31/2012	Beneficiary Eligibility	2.1 Benefit Plans	Addition of Benefit Plan: Benefit Plan ID: CSHCS-MC Benefit Plan Name: Children's Special Health Care Services – Managed Care Benefit Plan Description: This plan is assigned to CSHCS beneficiaries who also have full Medicaid coverage and are enrolled in a Medicaid Health Plan (MHP). The MHP receives a capitation payment and provides the full range of covered services. Specific services carved out of the MHP contract will remain covered through MA Fee-For-Service. Type: Managed Care Funding Source: V Covered Services: 1, 33, 47, 48, 50, 86, 88, 98, AL, UC

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Beneficiary Eligibility	2.1 Benefit Plans	In the table in the 2nd paragraph, the 3rd sentence of the Benefit Plan Description for NEMT was revised as follows: NEMT for services covered by the Medicaid Health Plan is provided under the Medicaid Health Plan Benefit Plans (MA-MC, MME-MC, and CSHCS-MC).
		Beneficiary Eligibility	9.1 Enrollment	In the table under "Excluded Enrollment": <ul style="list-style-type: none"> The 3rd bullet point was removed ("People who are dually Medicare/Medicaid eligible with program codes C, L, N or Q."). The 9th bullet point was revised to read ""People enrolled in the CSHCS Program without full Medicaid coverage." The burst box after the last bullet point was revised to read: "If one member of a family resides in a nursing facility or loses Medicaid eligibility, this does not ..." Addition of bullet point "People receiving Private Duty Nursing Services."
		Beneficiary Eligibility	9.4 CHAMPS Eligibility Inquiry	The 1st bullet point was revised to read: <ul style="list-style-type: none"> Benefit Plan ID of MA-MC or CSHCS-MC
		Beneficiary Eligibility	10.1 Coverage	In the 3rd paragraph, the 2nd sentence was revised to read: A beneficiary who has both CSHCS and FFS Medicaid or CSHCS ... and a 3rd sentence was added: A beneficiary who has CSHCS and is enrolled in a Medicaid Health Plan may receive 20 outpatient mental health visits through the Medicaid Health Plan. Provision of outpatient mental health services through the Medicaid Health Plan is available pursuant to the Beneficiary Eligibility subsection of the Mental Health/Substance Abuse chapter.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Beneficiary Eligibility	10.2 Identifying CSHCS on the CHAMPS Eligibility Inquiry	The 3rd paragraph was deleted ("CSHCS beneficiaries receive services through the FFS system.").
		Children's Special Health Care Services	Section 4 - Application Process	A 5th paragraph was added and reads: When a medical report is submitted to CSHCS on behalf of a beneficiary with full Medicaid coverage and the CSHCS medical consultant determines that the beneficiary is medically eligible for CSHCS, the beneficiary is automatically enrolled in CSHCS without completing the CSHCS application.
		Children's Special Health Care Services	Section 7 - Effective Date	In the 1st paragraph, 2nd bullet point, a sub-bullet point was added: ➤ The CSHCS coverage begin date for beneficiaries enrolled in an MHP is dependent upon the date of the event that qualifies the beneficiary for CSHCS. The CSHCS begin date is the first day of the month of this qualifying event (up to six months from the date MDCH received the medical report). The enrollee will remain enrolled in the MHP.
		Medicaid Health Plans	1.2 Services Excluded from MHP Coverage but Covered by Medicaid	The following bullet point was added: • Private Duty Nursing Services
MSA 12-48	10/1/2012	Ambulance	2.1.A. Fixed Wing Air Ambulance	In the 2nd paragraph, the 1st sentence was revised to read: Air ambulance transport and mileage provided by fixed wing aircraft ...

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 12-51	11/1/2012	Coordination of Benefits	2.6.F. Medicaid Liability	<p>The 6th paragraph was revised to read:</p> <p>MDCH does not pay for services denied by Medicare or commercial health insurance plans due to noncompliance with Medicare or the commercial health insurance plan requirements. If the provider's service would have been covered and payable by Medicare or the commercial health insurance plan but some requirement of the plan was not met, MDCH will deny the claim. The provider and the beneficiary both have equal responsibility for complying with Medicare or the commercial health insurance plan requirements.</p> <p>Common noncompliance denials include, but are not limited to,:</p> <ul style="list-style-type: none"> • Failure to obtain a referral from a participating primary care provider (PCP). • Failure to be seen by a participating provider. • Failure to be seen in a participating place of service. • Failure to obtain a second opinion. • Failure to obtain prior authorization. <p>In instances where MDCH has denied payment or made a post-payment recovery due to noncompliance, it is the provider's responsibility to remediate with the primary payer prior to re-billing with Medicaid.</p> <p>Note: This also applies to Fee-for-Service pharmacy claims, particularly claims submitted with Other Coverage Code (OCC) "3: Other Coverage Billed - Claim Not Covered." When the National Council for Prescription Drug Programs (NCPDP) standard does not provide MDCH with a point-of-sale (POS) mechanism to verify full compliance with Medicare or commercial health insurance plan requirements, MDCH will review and recover monies for noncompliance on a post payment basis (e.g., when the primary payer denies the claim with NCPDP rejection code "75: Prior Authorization Required" and MDCH is unable to verify at the POS whether prior authorization was requested and denied versus prior authorization not requested).</p>

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 12-52	11/1/2012	Federally Qualified Health Centers	5.6 New FQHC Prospective Payment Rate	<p>Subsection text was revised in its entirety to read:</p> <p>An entity that initially qualifies as an FQHC after fiscal year 2000 will be paid as follows:</p> <ul style="list-style-type: none"> • Upon enrollment, an interim prospective payment rate (PPR) will be established for new FQHCs equal to the facility type average rate for the county in which they are located or the statewide average (if no previous average exists for the county subject to any limit applied to the specific facility type). The FQHC will be cost settled at the end of its first fiscal year of operation. • After the facility has been in operation for two full cost reporting periods, the average rate per visit for those two periods will be considered the revised PPR for the facility, subject to the following criteria: <ul style="list-style-type: none"> ➢ The first year will be inflated to the second fiscal year end using the appropriate Medicare Economic Index (MEI) factors. ➢ The PPR shall not exceed the Medicare limit (rural or urban depending upon classification) plus the Medicaid add-on amounts adjusted for MEI. <p>In subsequent years, the newly established FQHC shall be paid using the PPS methodology or an alternate MOA methodology. A newly established FQHC is eligible for quarterly payments. The amount of the quarterly payment will be estimated until the first reconciliation period.</p>
		Federally Qualified Health Centers	5.10.A. Increase/Decrease in Scope of Service	<p>In the 1st paragraph, the following text was added after the 1st sentence:</p> <p>Any facility approved for rebasing due to a change in scope of services shall be treated as a new facility. In order to qualify for a scope of service change, the cost related to the specific change must account for an increase or decrease to the existing PPR of five percent or greater. A facility that changes classification to a system utilizing a different rate limit or methodology shall be considered a change of scope (by default).</p>

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Rural Health Clinics	5.1 Establishing Rates for New Clinics	<p>Subsection text was revised in its entirety to read:</p> <p>An entity that initially qualifies as an RHC after fiscal year 2000 will be paid as follows:</p> <ul style="list-style-type: none"> • Upon enrollment, an interim prospective payment rate (PPR) will be established for new RHCs equal to the facility type average rate for the county in which they are located or the statewide average (if no previous average exists for the county subject to any limit applied to the specific facility type). The RHC will be cost settled at the end of its first fiscal year of operation. • After the facility has been in operation for two full cost reporting periods, the average rate per visit for those two periods will be considered the revised PPR for the facility, subject to the following criteria: <ul style="list-style-type: none"> ➤ The first year will be inflated to the second fiscal year end using the appropriate Medicare Economic Index (MEI) factors. ➤ For independent RHCs, the rebased PPR shall not exceed the Medicare limit. ➤ For provider-based RHCs (associated with a hospital with fewer than 50 enrolled beds), the PPR shall not exceed the statewide average cost per visit. The limit will increase annually at a minimum of the MEI factor. ➤ For provider-based RHCs (associated with a hospital with 50 or more beds), the PPR shall not exceed the Medicare limit.
		Rural Health Clinics	7.1 Scope of Service	<p>The following text was added to the paragraph:</p> <p>Any facility approved for rebasing due to a change in scope of services shall be treated as a new facility. In order to qualify for a scope of service change, the cost related to the specific change must account for an increase or decrease to the existing PPR of five percent or greater. A facility that changes classification to a system utilizing a different rate limit or methodology shall be considered a change of scope (by default). For example, an independent RHC that changes ownership to a provider-based RHC when the hospital has less than 50 beds is considered to have a change of scope.</p>

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 12-53	11/1/2012	Medical Supplier	Throughout the chapter	Revision of information relative to mobility and custom seating coverage, prior authorization, and evaluation of beneficiaries in the community and in nursing facilities.
		Nursing Facility Coverages	10.8.C. Prior Authorization	The title for form MSA-1656 was revised to read "Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices."
		Acronym Appendix		Addition of: MRADL – Mobility Related Activities of Daily Living
		Glossary Appendix		Addition of: Mobility Related Activities of Daily Living (MRADL) Daily activities (e.g., grooming, dressing, etc.) the beneficiary is capable of performing with the aid of mobility equipment.
		Forms Appendix		Addition of: MSA-1653-D Complex Seating and Mobility Device Prior Approval-Request/Authorization Revision of: <ul style="list-style-type: none"> • MSA-1656 Mobility and Seating Evaluation and Justification now reads "Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices", and has two addendums: <ul style="list-style-type: none"> ➤ Addendum A: Mobility/Seating ➤ Addendum B: Strollers, Gait Trainers, Standers, Car Seats, and Children's Positioning Chairs • MSA-1653-B Special Services Prior Approval-Request/Authorization

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 12-54	11/1/2012	Local Health Departments	6.1 Full Cost Methodology	<p>Subsection text was revised in its entirety to read:</p> <p>The term full cost reimbursement, as used in this chapter, means the cost of providing Medicaid services as determined by information provided on the Michigan Medicaid Cost Report for LHDs. Full cost is derived from the amounts the LHD receives from Medicaid Fee-for-Service and Medicaid Health Plan payments, other third party insurers, quarterly payments from MDCH, and initial and final settlements. A combination of local and state general funds provides the basis for full cost reimbursement and is used for claiming federal financial participation. MDCH will reimburse the LHD for its services, other than dental services, at reasonable and allowable actual incurred costs according to 42 CFR § 431.615(c)(4).</p> <p>To receive full cost reimbursement, qualified providers must supply the MDCH Hospital and Clinic Reimbursement Division (HCRD) with a Michigan Medicaid cost report.</p>

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Michigan Department of Community Health

Supplemental Bulletin List



October - December 2012

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. **NOTE:** As stated in MSA Bulletin 09-60 issued December 1, 2009, this list includes only those bulletins which have not been formally incorporated into the Medicaid Provider Manual maintained on the MDCH website. The updated list showing all bulletins for the current calendar year 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	COMMENTS
12/1/2012	MSA 12-68	Sanctioned Providers Update	All Providers	
12/1/2012	MSA 12-67	Updates to the Medicaid Provider Manual; ICD-10 Update	All Providers	
12/1/2012	MSA 12-66	Physician Primary Care Rate Increase	Practitioners, Hospitals, Medicaid Health Plans	
12/1/2012	MSA 12-65	Claim Predictive Modeling	All Providers	
12/1/2012	MSA 12-63	Sanctioned Provider Notification Process	All Providers	
12/1/2012	MSA 12-62	Outpatient Prospective Payment System and Ambulatory Surgical Center Reduction Factor	Hospitals, Ambulatory Surgical Centers (ASCs), Hospital-Owned Ambulance, Comprehensive Outpatient Rehabilitation Facilities, Rehab Agencies, Freestanding Dialysis Centers, Medicaid Health Plans, County Health Plans	



Michigan Department of Community Health

Supplemental Bulletin List



October - December 2012

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	COMMENTS
12/1/2012	MSA 12-61	DRG Grouper Update, DRG Rate Update, Per Diem Rate Update, Conversion from Date of Admission Driven Coding and Reimbursement to Date of Discharge	Hospitals, Medicaid Health Plans	
12/1/2012	MSA 12-60	Nursing Facility Reimbursement for Extended Period Cost Reports	Nursing Facilities	
12/1/2012	MSA 12-59	Elective, Non-Medically Indicated, Delivery Prior to 39 Weeks Completed Gestation	Inpatient Hospitals, Physicians, Medical Clinics, Federally Qualified Health Centers, Rural Health Clinics	
12/1/2012	MSA 12-58	Elimination of Maximum Daily Dollar Limits for Laboratory Services	Practitioners, Family Planning Clinics, Medical Clinics, Independent Laboratories	
12/1/2012	MSA 12-57	Borderland Nursing Facilities Serving Michigan Medicaid Beneficiaries	Nursing Facilities, County Medical Care Facilities, Hospital Long-Term Care Units, Hospital Swing Beds	
11/1/2012	MSA 12-56	Sanctioned Providers Update	All Providers	A complete list of sanctioned providers is available on the Michigan Department of Community Health (MDCH) website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> List of Sanctioned Providers
11/1/2012	MSA 12-55	Medicaid Provider Screening/ Enrollment and Program Integrity	All Providers	



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10/1/2012	MSA 12-50	Sanctioned Providers Update	All Providers	A complete list of sanctioned providers is available on the Michigan Department of Community Health (MDCH) website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> List of Sanctioned Providers
10/1/2012	MSA 12-49	Disproportionate Share Hospital (DSH) Process	Hospitals	
10/1/2012	MSA 12-47	Optometrist Electronic Health Record (EHR) Incentive Program Participation	Optometrists, Rural Health Clinics, Federally Qualified Health Centers	
8/31/2012	MSA 12-45	Sanctioned Providers Update	All Providers	A complete list of sanctioned providers is available on the Michigan Department of Community Health (MDCH) website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> List of Sanctioned Providers
8/31/2012	MSA 12-42	Medicaid Enrollment of Physician Assistants and Nurse Practitioners	All Providers	
8/31/2012	MSA 12-39	Primary Specialty Designation by Physicians	Practitioners, Outpatient Hospitals, Medicaid Health Plans, Federally Qualified Health Centers, Local Health Departments, Rural Health Clinics, Tribal Health Centers	



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8/31/2012	MSA 12-37	Rate Increase for Obstetrical Services	Practitioners, Outpatient Hospitals, Medicaid Health Plans, Federally Qualified Health Centers, Local Health Departments, Rural Health Clinics, Tribal Health Centers	