MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 14-37

Distribution: All Providers

Issued: August 28, 2014

Subject: Updates to the Medicaid Provider Manual; ICD-10 Project Update; New Coverage of Existing Code; Discontinuing Coverage of Existing Codes; Provider Portal; Nursery-Related Revenue Codes; Pre-admission Diagnostic Services; MIChild Eligibility Manual

Effective: As Indicated

Programs Affected: Medicaid, Healthy Michigan Plan, 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 October 2014 update of the online version of the Medicaid Provider Manual. The manual is located at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Policy Manual.

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.

Please refer to the online version of this bulletin at www.michigan.gov/medicaidproviders >> Policy and Forms to view the attachments that describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change.

ICD-10 Project Update

In a final rule issued on July 31, 2014 by the U.S. Department of Health and Human Services, the ICD-10 compliance date has been changed from October 1, 2014 to October 1, 2015. The continued use of ICD-9-CM will be required for Health Insurance Portability and Accountability Act (HIPAA) covered entities through September 30, 2015. For clarification, the new implementation date replaces the previous date(s) provided in Bulletin MSA-13-33 regarding claims processing guidance.

MDCH encourages providers to continue communications with software vendors, billing agents and/or service bureaus to ensure systems and procedures will support the use of ICD-10 code sets on all HIPAA transactions by the compliance date. Testing of ICD-10 coded transactions remains available through Business-to-Business (B2B) testing.

Any questions regarding ICD-10 implementation should be directed to MDCH-ICD-10@michigan.gov. Providers should continue to frequently check the MDCH website at www.michigan.gov/5010icd10 for ICD-10 updates. ICD-10 training availability is posted on the MDCH website at www.michigan.gov/medicaidproviders >>Hot Topics >> Medicaid Provider Training Sessions.

New Coverage of Existing Code

Effective July 1, 2014 (retroactive coverage), MDCH will cover Healthcare Common Procedure Coding System (HCPCS) code Q9970 – Injection, Ferric Carboxymaltose, 1 mg.

Discontinuing Coverage of Existing Codes

MDCH will discontinue coverage of the following codes effective October 1, 2014:

90287	90288	90291	90386	90389	J0205	J0350
J1180	J1835	J2460	J2725	J2940	J3110	J3365

Provider Portal

Medicaid Code and Rate Reference

MDCH has launched a new online service, Medicaid Code and Rate Reference, which is accessible via the Provider Portal menu within the Community Health Automated Medicaid Processing System (CHAMPS). With code search capabilities, the Medicaid Code and Rate Reference tool enables providers to query real-time information specific to coverage of services. Information includes, but is not limited to, the following:

- Age range considerations,
- Documentation requirements,
- Prior authorization and conditions that may bypass these requirements,
- Service limitations, and
- Rate information.

In the future, many of the currently posted databases may have a revised format (i.e., code and rate information only) since the supplemental information will be available real-time by accessing the Medicaid Code and Rate Reference tool.

Any questions should be directed to Provider Inquiry; phone toll-free 800-292-2550 or email at providersupport@michigan.gov. To request or view upcoming training sessions, please refer to the MDCH website at www.michigan.gov/medicaidproviders >>Communications and Training>>Medicaid Provider Training Sessions.

Nursery-Related Revenue Codes

Effective for dates of service (DOS) on and after October 1, 2014, all nursery-related Revenue Codes (i.e., 0170, 0171, 0172, 0173, 0174, 0179) will be covered by MDCH. Designated providers with an alternate weight assignment, per current Medicaid policy, may continue to use Revenue Code 0174 for Neonatal Intensive Care Unit (NICU) admissions.

Preadmission Diagnostic Services

On June 25, 2010, regulatory changes were signed into law by the President under the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010," Pub. L. 111-192. The law impacted the interpretation of the long standing Medicare three-day payment policy. Per Bulletin MSA 10-60, issued December 1, 2010, MDCH follows Medicare policy for all preadmission diagnostic services and other preadmission services (outpatient services treated as inpatient) with a few exceptions in compliance with the law. All non-diagnostic services rendered in the three-day window prior to the inpatient hospital admission may not be billed separately and must be bundled into the inpatient stay, unless the hospital can document they are unrelated services. MDCH aligns with Medicare billing guidelines. MDCH's Preadmission Diagnostic Services policy does not apply to ambulance providers, freestanding dialysis centers or inpatient rehabilitation hospitals.

MIChild Eligibility Manual

The MIChild Eligibility Manual has been updated on the MDCH MIChild website at www.michigan.gov/michild. The MIChild Eligibility Manual contains information regarding eligibility criteria, special populations, the application process, premiums, and other general information. Changes to the MIChild Eligibility Manual will be incorporated on a quarterly basis and will be communicated to providers via a quarterly update bulletin.

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 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

Michigan Department of Community Health

Medicaid Provider Manual
October 2014 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	8.1 Free Choice	Text was revised to read: ... enrolled in a Medicaid Health Plan (MHP), County Health Plan (CHP), or otherwise specified.	Removal of obsolete information.
Beneficiary Eligibility	2.1 Benefit Plans	Addition of benefit plan: **Benefit Plan ID:** HHBH **Benefit Plan Name:** Health Home Behavioral Health **Benefit Plan Description:** Medicaid Health Home services are intended for beneficiaries with Severe Mental Illness (SMI) who have experienced high rates of inpatient hospital admissions or high rates of hospital emergency department usage and who may or may not have other chronic physical health conditions that are amenable to care coordination and management by the health home (i.e., congestive heart failure, insulin dependent diabetes, chronic obstructive pulmonary disorder, seizure disorder). Individuals to whom these conditions apply may be determined by the state to be eligible to receive Health Home services. **Type:** Managed Care Organization **Funding Source:** XIX **Covered Services (Service Type Codes):** AI, MH Addition of benefit plan: **Benefit Plan ID:** PIHP-HMP **Benefit Plan Name:** PIHP Healthy Michigan **Benefit Plan Description:** This benefit plan provides managed care specialty behavioral health services for individuals enrolled in Healthy Michigan. **Type:** Managed Care Organization **Funding Source:** XIX **Covered Services (Service Type Codes):** AI, MH	Updates.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	For the Benefit Plan ID of "Plan First!", the statement "Discontinued as of July 1, 2014." was removed.	Update.
Beneficiary Eligibility	2.3 Level of Care Codes	In the 1st paragraph, in the table, Benefit Plan ID information for LOC Code 07 was revised to read: MA-HMP-MC (Healthy Michigan Plan Managed Care), MA-MC (Medicaid Managed Care), CSHCS-MC (Children's Special Health Care Services – Managed Care), or MME-MC (Medicare – Medicaid Dually Eligible – Managed Care)	Correction.
Beneficiary Eligibility	9.1 Enrollment	Under "Excluded Enrollment", the 2nd bullet point was removed.	Removal of obsolete information.
Beneficiary Eligibility	9.1 Enrollment	In the table, under "Excluded Enrollment", the 6th bullet point was revised to read: • People receiving nursing facility services. (Refer to …	Clarification.
Billing & Reimbursement for Institutional Providers	6.2.F. Loss/Gain Medicaid Eligibility	In the 1st paragraph, the following bullet point was added: • The admission date must reflect the date the order to admit the beneficiary was written.	Addition will help to clarify the process.
Billing & Reimbursement for Institutional Providers	6.2.G. Medicare	In the 4th paragraph, in the table, under: ➢ Medicare Part A Exhausted Prior to Stay, the 1st bullet point was revised to read: o Report Type of Bill 0111 and enter occurrence code … ➢ Medicare Part A Exhausted During Stay, the 1st bullet point was revised to read: o Report Type of Bill 0111 and enter occurrence code …	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	7.22 Preadmission Diagnostic Services	The 2nd paragraph was revised to read: MDCH does not differentiate any specialty hospitals or facilities referenced in the CMS policy (i.e., critical access hospital [CAH], cancer, etc.). (NOTE: This policy does not apply to ambulance providers, freestanding dialysis centers or inpatient rehabilitation hospitals.) MDCH will use ...	Clarification.
Billing & Reimbursement for Institutional Providers	8.2.C. Offset to Patient-Pay Amount for Noncovered Services	The following text was added at the end of the 2nd paragraph: The offset must be reported for the month that the services were provided.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Professionals	6.6 Children's Waiver Program	Information in the table was placed in alphabetical order by subject, and the following revisions were made. **"Coding"** information was removed. Under **"Modifiers"**, text was revised to read: Use the appropriate HCPCS modifier that represents the level of the professional providing the service. Refer to the MDCH CMHSP Children's Waiver Database on the MDCH website for the appropriate modifier/procedure code combination. Refer to other billing instructions in this chapter for special circumstances requiring the use of a modifier. Under **"Units of Service"**, text was revised to read: Report the units of service/quantity based on the service that was performed. Some services by description are in 15-minute increments; if an hour of service was performed, this would be reported as 4 units of service. If the code description is per hour and 2 hours of service were performed, the reported units would be 2. Refer to the MDCH CMHSP Children's Waiver Database for the allowable units. Under **"Respite Services to More than One Beneficiary"**, text was revised to read: When services are provided to more than one beneficiary at the same time, use the TT modifier on each claim. If services are performed for more than one beneficiary at the same time by an LPN or RN, use the LPN/RN modifier, as appropriate, in addition to the TT modifier.	Update.

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		Under **"Holiday Pay"**, text was revised to read: Additional reimbursement is allowed under the Children's Waiver Program for Community Living Supports (CLS) and Respite Services performed on a holiday. Information regarding the specific procedure codes and associated holiday rates is available on the MDCH website in the MDCH CMHSP Children's Waiver Database. (Refer to the Directory Appendix for website information.) Current recognized holidays are: New Year's Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas Day. A holiday begins at 12:00 a.m. and ends at 12:00 midnight. Under **"Prior Authorization"**, text was revised to read: Refer to the Mental Health/Substance Abuse Chapter, Children's Waiver Section for information regarding prior authorization. **"Fee Screens"** information was removed.	Update.
Billing & Reimbursement for Professionals	6.7 Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Program	Information in the table was placed in alphabetical order by subject, and the following revisions were made. **"Coding"** information was removed. Under **"Modifiers"**, text was revised to read: Use the appropriate HCPCS modifier that represents the level of the professional providing the service. Refer to the MDCH CMHSP Serious Emotional Disturbance (SED) Waiver Database on the MDCH website for the appropriate modifier/procedure code combination.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
		Under **"Units of Service"**, text was revised to read: Report the units of service/quantity based on the service that was performed. Some services by description are in 15-minute increments; if an hour of service was performed, this would be reported as 4 units of service. If the code description is per hour and 2 hours of service were performed, the reported units would be 2. Refer to the MDCH CMHSP Serious Emotional Disturbance (SED) Waiver Database for the allowable units. Under **"Holiday Pay"**, text was revised to read: MDCH allows additional reimbursement under the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW) Program for Community Living Supports (CLS) and Respite Services performed on a holiday. Information regarding the specific procedure codes and associated holiday rates is available on the MDCH website in the MDCH CMHSP Serious Emotional Disturbance (SED) Waiver Database. (Refer to the Directory Appendix for website information.) Current recognized holidays are: New Year's Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas Day. A holiday begins at 12:00 a.m. and ends at 12:00 midnight. **"Modifier"** was revised to read **"Services to More than One Beneficiary"** and text was revised to read: A modifier is required to indicate that services were provided to more than one beneficiary at a time for Community Living Supports (CLS), Community Wraparound and Respite Services. When services are provided to more than one beneficiary at the same time, use the TT modifier on each claim. Under **"Prior Authorization"**, text was revised to read: Community Transition Services require prior authorization. **"Fee Screens"** information was removed.	
Billing & Reimbursement for Professionals	6.8.E. Place of Service Codes	Under "DMEPOS", the following bullet point was added: • 04 – Homeless Shelter	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Adult Benefits Waiver	3.2 Substance Abuse Services	The 4th bullet point was revised to read: ➢ Federal Food and Drug Administration (FDA) approved pharmacological supports for Methadone only; or	Removal of obsolete information. (LAAM is no longer available for use/no longer available as a medication.)
Ambulance	2.1.A. Fixed Wing Air Ambulance	In the 1st paragraph, "Commission on Accreditation of Air Medical Services (CAAMS)" was revised to read "Commission on Accreditation of Medical Transport Systems (CAMTS)".	Update.
Dental	2.5 Loss or Change in Eligibility	Subsection text was revised in its entirety to read: No service is covered after loss of eligibility except for the following services: • Endodontic Therapy • Complete and Partial Dentures • Laboratory-Processed Crowns Reimbursement for these services is only allowed under the following circumstances: • Services were started prior to the loss of eligibility. • For complete or partial dentures and laboratory-processed crowns, impressions were taken prior to the loss of eligibility. • Services are completed within 30 days of change and/or loss of eligibility. Conditions not eligible for reimbursement include: • If a beneficiary's Medicaid eligibility is terminated after extractions were performed, but prior to the initial impressions. The extractions alone do not qualify the beneficiary for dentures. • Immediate dentures. The date of service on the claim is the date the endodontic therapy was started or the date of the initial impressions for complete or partial dentures and laboratory-processed crowns.	Clarification. (Note: Information previously found in the last paragraph was relocated to 6.6.A. General Instructions. Reason: This is not a loss or change in eligibility statement. The statement pertains to dentures only and belongs under Prosthodontics.

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Dental	6.1.E.3. Assessment of a Patient	Subsection text was revised in its entirety to read: An assessment of a patient is a clinical evaluation performed by a dental hygienist operating in a public health setting or an approved Public Act 161 of 2005 (PA 161) program. Assessment services performed within the scope of dental hygiene practice can be provided to identify signs of disease, malformation or injury and the need for referral for examination, diagnosis and treatment. An assessment of a patient is a benefit for all ages. The assessment must include written documentation of the beneficiary's dental and medical history. Written documentation of significant clinical findings and the appropriate referral is required. The assessment code cannot be used when a dentist is on site to perform the examination. An oral examination by the dentist always supersedes the assessment of a patient in place of service settings where the dentist is present. It can be billed in conjunction with other dental hygiene services, but may not be billed on the same date of service as other oral evaluation services.	Clarification of policy.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.6.A. General Instructions	Subsection was revised in its entirety to read: Complete and partial dentures are benefits for all beneficiaries. All dentures require prior authorization (PA). Providers must assess the beneficiary's general oral health and provide a five-year prognosis for the prosthesis requested. An upper partial denture PA request must also include the prognosis of six sound teeth. Complete or partial dentures are authorized when one or more of the following conditions exist: • One or more anterior teeth are missing. • There are less than eight posterior teeth in occlusion (fixed bridges and dentures are to be considered occluding teeth). • An existing complete or partial denture cannot be made serviceable through repair, relining, adjustment, or duplicating (rebasing) procedures. If an existing complete or partial denture can be made serviceable, the dentist should provide the needed restorations to maintain use of the existing removable prosthesis. This includes extracting teeth, adding teeth to the existing prosthesis, and removing hyperplastic tissue as necessary to restore the functionality of the complete or partial denture. Before the final impressions are taken for the fabrication of a complete or partial denture, adequate healing necessary to support the prosthesis must take place following the completion of extractions and/or surgical procedures. This includes the posterior ridges of any immediate denture. When an immediate denture is authorized involving the six anterior teeth (cuspid to cuspid), this requirement is waived. Reimbursement for a complete or partial denture includes all necessary adjustments, relines, repairs, and duplications within six months of insertion. This also includes such services necessary for an immediate upper denture when authorized. If any necessary adjustments or repairs are identified within the six month time period but are not provided until after the six month time period, no additional reimbursement is allowed for these services.	Clarification.

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		When denture services have commenced but irreversible circumstances have prevented delivery, the dentist should bill using the Not Otherwise Classified (NOC) procedure code. A copy of the lab bill and an explanation in the Remarks section of the claim must be included. Providers are paid a reduced rate to offset a portion of the costs incurred. It is the expectation that the probability of removable appliances being delivered and follow-up treatment completed is assessed prior to the initiation of treatment to evaluate whether the treatment is appropriate for the specific patient. Contact the Program Review Division (PRD) regarding the requirements for incomplete dentures. (Refer to the Directory Appendix for contact information.)	
Hospital	Section 2 – Prior Authorization	In the chart in the 1st paragraph, the following text (under "Service") was revised: • Outpatient Occupational Therapy (OT) (after the initial 12 months of treatment or 144 visits) • Physical Therapy (PT) (after the initial 12 months of treatment or 144 visits) • Outpatient Speech-Language Pathology (after the initial 12 months of treatment or 144 visits)	Update/correction.
Hospital	3.7.A. Childbirth Education	The following text was added at the end of the 1st paragraph: MDCH does not separately cover on-line (a type of distance learning) education classes.	Clarification.
Hospital	3.21.F. Coordinating Agencies	The 4th bullet point was revised to read: ➢ Food and Drug Administration (FDA) Approved Pharmacological Supports (Methadone)	Removal of obsolete information. (LAAM is no longer available for use/no longer available as a medication.)

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Medical Suppliers	1.5 Medical Necessity	In the 2nd paragraph, the 3rd sentence was revised to read: Neither a physician, nurse practitioner (NP) or physician assistant (PA) order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it is signed by the treating/ordering physician, NP or PA. In the 3rd paragraph, the 6th bullet point was revised to read: The service/device is ordered by the treating physician, NP, or PA (for CSHCS beneficiaries, the order must be from the pediatric subspecialist) and clinical documentation from the medical record supports the medical necessity for the request (as described above) and substantiates the practitioner's order.	Clarification.
Medical Suppliers	1.5.A. Prescription Requirements	In the 1st paragraph: ➢ the 4th bullet point was revised to read: o Prescribing physician's, NP's or PA's name, address, and telephone number; ➢ the 5th bullet point was revised to read: o Prescribing physician's, NP's or PA's signature (a stamped or co-signature will not be accepted); ➢ the 9th bullet point was revised to read: o Start date of order if different from the physician's, NP's or PA's signature date.	Clarification.
Medical Suppliers	2.19 Incontinent Supplies	Under "Services Covered Through the Contract", HCPCS Code A4335, an "X" was added to the "CSHCS Coverage" column.	Correction.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	1.7 Definition of Terms	The following text was added to the definition for Qualified Mental Health Professional (QMHP): NOTE: If an individual was hired and performed the role of a QMHP prior to January 1, 2008 and later transfers to a new agency, his/her QMHP status will be grandfathered into the new agency. The following text was added to the definition for Qualified Intellectual Disability Professional (QIDP): NOTE: If an individual was hired and performed the role of a QIDP prior to January 1, 2008 and later transfers to a new agency, his/her QIDP status will be grandfathered into the new agency.	Reflects the most recent change made to the Provider Qualifications Chart.
Mental Health/ Substance Abuse	8.5.B. Inpatient Admission Criteria: Adults	In the 3rd paragraph, under "Diagnosis", text was revised to read: The beneficiary must be suffering from a mental illness reflected in a primary, validated, current version of DSM or ICD diagnosis (not including V codes).	Current version of the DSM no longer uses an Axis system for diagnosis.
Mental Health/ Substance Abuse	8.5.C. Inpatient Admission Criteria: Children Through Age 21	In the 3rd paragraph, under "Diagnosis", text was revised to read: The beneficiary must be suffering from a mental illness reflected in a primary, validated, current version of DSM or ICD diagnosis (not including V codes).	Current version of the DSM no longer uses an Axis system for diagnosis.
Mental Health/ Substance Abuse	8.5.D. Inpatient Psychiatric Care – Continuing Stay Criteria: Adults, Adolescents and Children	In the 4th paragraph, under "Diagnosis", text was revised to read: The beneficiary has a validated current version of DSM or ICD mental disorder (excluding V codes) that remains the principal diagnosis for purposes of care during the period under review.	Current version of the DSM no longer uses an Axis system for diagnosis.
Mental Health/ Substance Abuse	12.1 Covered Services - Outpatient Care	In the 3rd paragraph, the 2nd sentence was revised to read: Authorized decisions on length of stay, including continued stay, change in level of care, and discharge, must be based on the American Society of Addiction Medicine (ASAM) Criteria.	The ASAM Criteria has been updated with a different name and changed the numbering for the various levels of care in the new edition of the manual.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	12.1.A. Eligibility	In the 1st paragraph, the 5th and 6th bullet points were revised to read: • The American Society of Addiction Medicine (ASAM) Criteria are used to determine substance abuse treatment placement/admission and/or continued stay needs. • The service is based on a level of care determination using the six assessment dimensions of the current ASAM Criteria: ...	The ASAM Criteria has been updated with a different name and changed the numbering for the various levels of care in the new edition of the manual.
Mental Health/ Substance Abuse	12.1.D. Service Intensity	In the 1st paragraph, the bullet point list was revised to read: • Level 0.5 – Early Intervention • Level 1.0 – Outpatient • Level 2.1 – Intensive Outpatient • Level 2.5 – Partial Hospitalization Services	The ASAM Patient Placement Criteria changed the numbering for the various levels of care in the latest edition of the manual.
Mental Health/ Substance Abuse	12.1.D. Service Intensity	In the 2nd paragraph, information in the 1st column of the table was revised to read: ASAM Level 0.5 ASAM Level 1.0 ASAM Level 2.1 ASAM Level 2.5	The ASAM Criteria has been updated with a different name and changed the numbering for the various levels of care in the new edition of the manual.
Mental Health/ Substance Abuse	12.2.C. Eligibility Criteria	In the 2nd paragraph, the 1st sentence was revised to read: All six dimensions of the American Society of Addiction Medicine (ASAM) criteria must be addressed:	The ASAM Criteria has been updated with a different name and changed the numbering for the various levels of care in the new edition of the manual.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	12.2.D. Admission Criteria	The 1st paragraph was revised to read: Decisions to admit an individual for methadone maintenance must be based on medical necessity criteria, satisfy the LOC determination using the six dimensions of the ASAM Criteria, and have an initial diagnostic impression of opioid dependency for at least one year based on current DSM criteria.	The ASAM Criteria has been updated with a different name and changed the numbering for the various levels of care in the new edition of the manual.
Mental Health/ Substance Abuse	12.3 Sub-Acute Detoxification	In the 3rd paragraph, the 2nd sentence was revised to read: Client placement to setting and to level of intensity must be based on ASAM Criteria and individualized determination of client need. The 4th paragraph was revised to read: The following combinations of sub-acute detoxification settings and levels of intensity correspond to the LOC determination based on the ASAM Criteria. In the 4th paragraph, the 1st bullet point was revised to read: • Outpatient Setting ➢ Ambulatory Detoxification without extended on-site monitoring corresponding to ASAM Level 1-WM, or ambulatory detoxification with extended on-site monitoring (ASAM Level 2-WM). ➢ Outpatient setting sub-acute detoxification must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed medical personnel as needed. ASAM Level 2-WM ambulatory detoxification services … • Residential Setting ➢ Clinically Managed Residential Detoxification - Non-Medical or Social Detoxification Setting: Emphasizes peer and social support for persons who warrant 24-hour support (ASAM Level 3.2-WM. … ➢ Medically Managed Residential Detoxification - Freestanding Detoxification Center: These services must be staffed 24-hours-per-day, seven-days-per-week by a licensed physician or by the designated representative of a licensed physician (ASAM Level 3.7-WM).	The ASAM Patient Placement Criteria changed the numbering for the various levels of care in the latest edition of the manual.

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CHAPTER	SECTION	CHANGE	COMMENT
		In the 6th paragraph, the 2nd bullet point was revised to read: • Admission to sub-acute detoxification must be made based on: ➢ Medical necessity criteria ➢ LOC determination based on an evaluation of the six assessment dimensions of the current ASAM Criteria.	
Mental Health/ Substance Abuse	12.4 Residential Treatment	In the 3rd paragraph, the 2nd bullet point was revised to read: • Admissions to Residential Treatment must be based on: ➢ Medical necessity criteria ➢ LOC determination based on an evaluation of the six assessment dimensions of the current ASAM Criteria.	The ASAM Criteria has been updated with a different name and changed the numbering for the various levels of care in the new edition of the manual.
Mental Health/ Substance Abuse	12.5 Excluded Services	In the 2nd paragraph, the 2nd bullet point was revised to read: • Laboratory services related to substance abuse (with the exception of lab services required for Methadone).	Removal of obsolete information. (LAAM is no longer available for use/is no longer available as a medication.)
Mental Health/ Substance Abuse	18.5 Independent Assessment	The 4th paragraph was revised to read: … who must possess a minimum of a master's degree from an accredited institution in one of the degree categories approved by the Behavioral Analyst Certification Board (BACB) every six months for every child that is receiving Early Intensive Behavioral Intervention (EIBI) and Applied Behavioral Intervention (ABI).	Text added to ensure understanding of the components of the independent assessment.
Mental Health/ Substance Abuse	18.6.A. Early Intensive Behavioral Intervention (EIBI)	In the 1st paragraph, the 2nd sentence was revised to read: This intensive intervention is available for children who have Autism Spectrum Disorder and an Autism Diagnostic Observation Schedule (ADOS-2) score that falls in the classification range of autism.	Autistic disorder is no longer a diagnosis due to changes in the DSM. The language that is provided is from the SPA.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	18.6.B. Applied Behavioral Intervention	In the 1st paragraph, the following text was inserted after the 1st sentence: This intervention is available for children who have Autism Spectrum Disorder, who are not receiving EIBI services, and who have an ADOS-2 score that falls in the classification range of autism or autism spectrum disorder.	Language from the SPA added to clarify this intervention.
Mental Health/ Substance Abuse	18.6.B. Applied Behavioral Intervention	In the 2nd paragraph, the following text was inserted after the 3rd sentence: The IPOS will be reviewed at regular intervals (minimally every three months).	Included to enforce the review standards for the IPOS.
MI Choice Waiver	Throughout the chapter	A full review of the chapter was done. A number of revisions were made which include updates and clarifications.	General updates and clarification.
Nursing Facility Coverages	9.5 Payment for Non-covered Services	The following text was inserted after the 1st sentence: The services would include services rendered by providers not enrolled in the Medicaid program. The offset to the patient-pay amount must be reported for the month that services were provided.	Clarification.
Outpatient Therapy	4.1 Emergency Prior Authorization	The 1st paragraph was revised to read: A provider may contact MDCH to obtain a verbal PA when the physician/physician assistant/nurse practitioner providing the medical clearance has indicated that it is medically necessary to provide the service within a 24-hour time period.	Clarification.
Outpatient Therapy	5.1.E. Serial Casting	In the 3rd paragraph, the 2nd sentence was revised to read: Either the referral for therapy services must specifically indicate that the beneficiary is being referred for serial casting, or the referring provider must provide written concurrence of any treatment plan, including serial casting.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Outpatient Therapy	5.1.F. Prescription Requirements	In the 1st paragraph • The 1st sentence was revised to read: MDCH requires a prescription from a physician/physician assistant/nurse practitioner for an OT evaluation and … • The 4th sentence was revised to read: An evaluation may be provided for the same medical diagnosis without PA twice in a 365-day period with a prescription. In the table in the 1st paragraph: • Under "Treatment Plan", the 6th bullet point was revised to read: Prescribing provider signature verifying … • Under "Initiation of Services", 2nd paragraph, the 2nd bullet point was revised to read: A copy of the signed and dated … • Under "Requirements of Continued Therapy", 2nd paragraph, 6th bullet point, the 2nd sentence was revised to read: The prescription must be hand-signed by the referring provider and dated …	Updating language to add physician assistants and nurse practitioners as providers who can order/prescribe PT, OT, and ST services. Makes language consistent with other areas of policy.
Outpatient Therapy	5.1.F. Prescription Requirements	Under "Maintenance/Monitoring Services", 1st paragraph, the last sentence was revised to read: PA is not required for these types of service for up to four times per 12-month period in the outpatient setting.	Update/correction.
Outpatient Therapy	5.2.E. Serial Casting	The 3rd paragraph was revised to read: … Either the referral for therapy services must specifically indicate that the beneficiary is being referred for serial casting, or the referring provider must provide written concurrence of any treatment plan, including serial casting. For CSHCS beneficiaries without dual Medicaid eligibility, the service must be directly related to the CSHCS-eligible diagnosis and must be referred by the beneficiary's assigned pediatric subspecialist. This may be met by the referring provider's dated signature on the PT plan of care.	Updating language to add physician assistants and nurse practitioners as providers who can order/prescribe PT, OT, and ST services. Makes language consistent with other areas of policy

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CHAPTER	SECTION	CHANGE	COMMENT
Outpatient Therapy	5.2.F. Prescription Requirements	The 1st sentence was revised to read: MDCH requires a prescription from a physician/physician assistant/ nurse practitioner for a PT evaluation … In the table: • Under "Evaluation", 1st paragraph, the 3rd sentence was revised to read: Evaluations may be provided for the same diagnosis without PA twice in a 365-day period with a prescription. • Under "Treatment Plan", 1st paragraph, the 6th bullet point was revised to read: Prescribing provider signature verifying … • Under "Initiation of Services", 4th paragraph, the 2nd bullet point was revised to read: A copy of the signed and dated … • Under "Continued Active Treatment", 2nd paragraph, the 6th bullet point was revised to read: A copy of the prescription, hand-signed by the referring provider and …	Updating language to add physician assistants and nurse practitioners as providers who can order/prescribe PT, OT, and ST services. Makes language consistent with other areas of policy.
Outpatient Therapy	5.2.F. Prescription Requirements	Under "Maintenance/Monitoring Services", 1st paragraph, the last sentence was revised to read: PA is not required for these types of services for up to four times in 12 months for the outpatient setting.	Update/correction.

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CHAPTER	SECTION	CHANGE	COMMENT
Outpatient Therapy	5.3.C. Referral for Speech Therapy	The subsection title was revised to read: Referral for Speech Therapy The 1st paragraph was revised to read: A referral from a physician/physician assistant/nurse practitioner is required for Medicaid coverage of speech therapy. The referral for speech therapy must … In the 2nd paragraph, the 2nd sentence was revised to read: A new referral must be made … In the 3rd paragraph, the 1st sentence was revised to read: A copy of the referral must be … In the table in the 3rd paragraph: • Under "Evaluation": ➢ 1st paragraph, the 3rd sentence was revised to read: These may be provided for the same diagnosis without PA twice in a 365-day period with a referral. ➢ 3rd paragraph, the 5th bullet point was revised to read: Voice – copy of the referring provider's medical assessment of … • Under "Treatment Plan": ➢ 1st paragraph, 6th bullet point, the 1st sentence was revised to read: Documentation of acceptance by referring provider of stated treatment plan. ➢ 2nd paragraph, the 1st sentence was revised to read: Referring provider acceptance of the speech therapy treatment plan must … ➢ 2nd paragraph, the 1st bullet point was revised to read: Phone call to the referring provider … ➢ 2nd paragraph, the 2nd bullet point was revised to read: Copy of the plan to the referring provider …	Updating language to add physician assistants and nurse practitioners as providers who can order/prescribe PT, OT, and ST services. Makes language consistent with other areas of policy.

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CHAPTER	SECTION	CHANGE	COMMENT
		➢ 2nd paragraph, the 3rd bullet point was revised to read: Referring provider's sign-off on the treatment plan ➢ The 3rd paragraph was revised to read: Documentation of the referring provider's acceptance of the … • Under "Initiation of Services", 5th paragraph, the 2nd bullet point was revised to read: A copy of the referring provider's signed and dated … • Under "Continued Active Treatment", 2nd paragraph, the 8th bullet point was revised to read: A copy of the referral, hand-signed by the referring provider and …	
Outpatient Therapy	5.3.C. Physician Referral for Speech Therapy	3rd paragraph, under "Maintenance/Monitoring Services", 1st paragraph, the last sentence was revised to read: In the outpatient setting, these types of service may be provided without PA up to four times per 12-month period.	Update/correction.
Outpatient Therapy	5.3.E. Evaluations and Follow-Up for Speech-Generating Devices	In the 1st paragraph, the last sentence was revised to read: The results of this evaluation must be shared with the prescribing provider. In the 4th paragraph, in the table under "Demographic Information", "Referring Physician" was revised to read "Referring Provider".	Updating language to add physician assistants and nurse practitioners as providers who can order/prescribe PT, OT, and ST services. Makes language consistent with other areas of policy.
Practitioner	5.4.B. Medical Supplies and Equipment	The 2nd sentence was revised to read: The physician (MD, DO, DPM, NP, PA) must prescribe/order these items.	Updating language to add physician assistants and nurse practitioners as providers who can order/prescribe PT, OT, and ST services. Makes language consistent with other areas of policy.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	Section 17 – Occupational Therapy	The 2nd sentence was revised to read: Evaluations must be ordered and a physician/physician assistant/nurse practitioner must prescribe therapy.	Updating language to add physician assistants and nurse practitioners as providers who can order/prescribe PT, OT, and ST services. Makes language consistent with other areas of policy.
Practitioner	17.1 Prescription Requirements	The 1st paragraph was revised to read: For Medicaid or CSHCS coverage of OT, a prescription must include: …	Updating language to add physician assistants and nurse practitioners as providers who can order/prescribe PT, OT, and ST services. Makes language consistent with other areas of policy.
Practitioner	17.2 Coverage Conditions	In the 6th paragraph, in the table under "Evaluations", 1st paragraph, the 1st sentence was revised to read: Evaluations are covered for the same medical diagnosis twice per year with a physician/physician assistant/nurse practitioner order.	Updating language to add physician assistants and nurse practitioners as providers who can order/prescribe PT, OT, and ST services. Makes language consistent with other areas of policy.
Practitioner	17.2 Coverage Conditions	In the table in the 6th paragraph: • Under "Initiation of Services", the last sentence was revised to read: For the outpatient hospital setting, up to 144 units of OT services may be provided in the initial 12-month treatment period. • Under "Requirements for Continued Active Therapy", 1st paragraph, the 1st sentence was revised to read: To request PA to continue therapy beyond the initial 60 days or 12 months, the OT must … • Under "Maintenance/Monitoring Services", 1st paragraph, the last sentence was revised to read: … up to four times per 60-day period in the home or 12-month period in the outpatient hospital settings.	Update/correction.

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CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	Section 18 – Physical Therapy	The 2nd sentence was revised to read: A physician/physician assistant/nurse practitioner must order the evaluations and …	Updating language to add physician assistants and nurse practitioners as providers who can order/prescribe PT, OT, and ST services. Makes language consistent with other areas of policy.
Practitioner	18.1 Prescription Requirements	In the 1st paragraph, the 1st sentence was revised to read: For Medicaid or CSHCS coverage, a physician/physician assistant/nurse practitioner prescription must include:	Updating language to add physician assistants and nurse practitioners as providers who can order/prescribe PT, OT, and ST services. Makes language consistent with other areas of policy.
Practitioner	18.2 Coverage Conditions	In the table in the 8th paragraph, under “Evaluations”, 1st paragraph, the 1st sentence was revised to read: Evaluations are covered for the same medical diagnosis twice per year with a physician/physician assistant/nurse practitioner order.	Updating language to add physician assistants and nurse practitioners as providers who can order/prescribe PT, OT, and ST services. Makes language consistent with other areas of policy.
Practitioner	18.2 Coverage Conditions	In the table in the 8th paragraph: • Under “Initiation of Services” the last sentence was revised to read: … or up to 144 times in the initial 12-month period in the outpatient hospital setting, or up to 20 times during a 75-day time period in the physician's office. • Under “Requirements for Continued Active Therapy”, 1st paragraph, the 1st sentence was revised to read: To request approval to continue therapy beyond the initial 60 days or 12 months, the PT must … • Under “Maintenance/Monitoring Services”, 1st paragraph, the last sentence was revised to read: up to four times per 60-day period in the home setting or 12 months in the outpatient hospital setting.	Update/correction.

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CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	Section 19 – Speech and Language Therapy	The 2nd sentence was revised to read: A physician/physician assistant/nurse practitioner must order the evaluations and prescribe the therapy.	Updating language to add physician assistants and nurse practitioners as providers who can order/prescribe PT, OT, and ST services. Makes language consistent with other areas of policy.
Practitioner	19.2 Coverage Conditions	In the table in the 10th paragraph: • Under "Evaluations", 1st paragraph, the 1st sentence was revised to read: Are covered for the same diagnosis twice per year with a physician/physician assistant/nurse practitioner prescription. • Under "Maintenance/Monitoring Services", 1st paragraph, the 2nd sentence was revised to read: … up to four times per 12-month period.	Updating language to add physician assistants and nurse practitioners as providers who can order/prescribe PT, OT, and ST services. Makes language consistent with other areas of policy. Update/correction.
Practitioner	19.2 Coverage Conditions	In the 10th paragraph, • Under "Initiation of Services", the 2nd sentence was revised to read: For this initial period, speech therapy may be provided up to a maximum of 36 times during the 12 consecutive calendar months in the hearing center or outpatient hospital. • Under "Requirements for Continued Active Therapy", 1st paragraph, the 1st sentence was revised to read: To request approval to continue therapy beyond the initial 60 days or 12 months, the PT must … • Under "Maintenance/Monitoring Services", 1st paragraph, the 2nd sentence was revised to read: In the outpatient hospital or hearing center, these types of service may be provided without prior approval for up to four times per 12-month period.	Update/correction.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	Section 24 – Physical Therapist	In the 1st paragraph, the 2nd sentence was revised to read: A physician/physician assistant/nurse practitioner must prescribe physical therapy services.	Updating language to add physician assistants and nurse practitioners as providers who can order/prescribe PT, OT, and ST services. Makes language consistent with other areas of policy.
Practitioner	20.1 Telemedicine Services	In the 1st paragraph, the 11th bullet point was revised to read: • Training service – Diabetes (Refer to the Diabetes Self-Management Education (DSME) Training Program subsection in the Hospital Chapter for specific program requirements)	Clarification.
School Based Services	2.1 Individuals with Disabilities Education Act Assessment and IEP/IFSP Development, Review and Revision	Under "Provider Qualifications", the following bullet points were added: • A licensed physician assistant (PA) • A licensed nurse practitioner (NP)	These providers can now enroll so they have been added.
School Based Services	2.2.A. Occupational Therapy Services	Under "Prescription", text was revised to read: Occupational therapy services must be prescribed by a physician, licensed physician assistant, or licensed nurse practitioner and updated annually. A stamped signature is not acceptable. Under "Assessments for Durable Medical Equipment", the 2nd sentence was revised to read: For example, an approved provider must order the assessment.	These providers can now enroll so they have been added.
School Based Services	2.2.B. Orientation and Mobility Services	Under "Prescription", text was revised to read: Orientation and mobility services must be prescribed by a physician, licensed physician assistant, or licensed nurse practitioner and updated annually. A stamped signature is not acceptable.	These providers can now enroll so they have been added.

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	2.2.C. Assistive Technology Device Services	Under "Prescription", text was revised to read: Assistive technology device services must be prescribed by a physician, licensed physician assistant, or nurse practitioner and updated annually. A stamped signature is not acceptable. Under "Assessments for Durable Medical Equipment", the 2nd sentence was revised to read: For example, an approved provider must order the assessment.	These providers can now enroll so they have been added.
School Based Services	2.3.A. Physical Therapy Services	Under "Prescription", text was revised to read: Physical therapy services must be prescribed by a physician, licensed physician assistant, or licensed nurse practitioner and updated annually. A stamped signature is not acceptable. Under "Assessments for Durable Medical Equipment", the 2nd sentence was revised to read: For example, an approved provider must order the assessment.	These providers can now enroll so they have been added.
School Based Services	2.3.B. Assistive Technology Device Services	Under "Prescription", text was revised to read: Assistive technology device services must be prescribed by a physician, licensed physician assistant, or licensed nurse practitioner and updated annually. A stamped signature is not acceptable. Under "Assessments for Durable Medical Equipment", the 2nd sentence was revised to read: For example, an approved provider must order the assessment.	These providers can now enroll so they have been added.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	2.4.A. Speech, Language and Hearing Therapy	Under "Prescription", text was revised to read: Speech, language and hearing services require an annual referral from a physician, licensed physician assistant, or licensed nurse practitioner. A stamped signature is not acceptable. Under "Evaluations for Speech Pathology Services", 3rd paragraph, the 5th bullet point was revised to read: • Voice - copy of the physician, licensed physician assistant, or licensed nurse practitioner medical assessment of the beneficiary's voice mechanism and the medical diagnosis. Under "Speech Assessments for Durable Medical Equipment", the 2nd sentence was revised to read: For example, an approved provider must order the assessment.	These providers can now enroll so they have been added.
School Based Services	2.4.B. Assistive Technology Device Services	Under "Prescription", text was revised to read: Assistive technology device services must be prescribed by a physician, licensed physician assistant, or licensed nurse practitioner and updated annually. A stamped signature is not acceptable. Under "Assessments for Durable Medical Equipment", the 2nd sentence was revised to read: For example, an approved provider must order the assessment. Under "Procedure Codes", "95595" was revised to read "92595."	These providers can now enroll so they have been added. Typo correction.
Tribal Health Centers	Section 4 – Substance Abuse	The last bullet point was revised to read: • Methadone	Removal of obsolete information. (LAAM is no longer available for use/is no longer available as a medication.)

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Tribal Health Centers	4.6 Noncovered Services	The 4th bullet point was revised to read: • Medications prescribed in the management or treatment of methadone	Removal of obsolete information. (LAAM is no longer available for use/is no longer available as a medication.)
Acronym Appendix		**Deletion of:** CAAMS - Commission on Accreditation of Air Medical Services LAAM - Methadone or Levo-Alpha-Acetyl-Methadol **Addition of:** CAMTS - Commission on Accreditation of Medical Transport Systems	Update.
Directory Appendix	MI Choice Waiver Resources	A number of revisions were made which include updates and clarifications.	General updates and clarification.
Forms Appendix	DCH-3890; Electronic Signature Verification Statement	On the instruction page, Provider Name "Instructions" were revised to read: The name of the Medicaid enrolled provider (for the School Based Services Program, this is one of the 56 Intermediate School Districts, Michigan School for the Deaf, or Detroit Public Schools).	Update.
Forms Appendix	MSA-2565-C; Facility Admission Notice	On page 2, in the lower right corner, "FIA Case No." was revised to read "DHS Case No.".	Update.

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Medicaid Provider Manual
October 2014 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 14-28	7/3/2014	*Plan First!* Family Planning Waiver	Table of Contents page	The text/burst box at the top of the Table of Contents page was revised to read: New enrollments into *Plan First*! ended on March 31, 2014**. (added per bulletin MSA 14-12)** The *Plan First!* waiver has been extended for coverage from July 1, 2014 until further notice for beneficiaries who: • Were enrolled in *Plan First!* on April 1, 2014, or may have been enrolled in Plan First! after April 1, 2014; and • Have not been determined eligible for full medical coverage **(added per bulletin MSA 14-28)**
MSA 14-27	7/1/2014	MI Choice Waiver		A number of changes were made throughout the MI Choice Waiver chapter relative to new MI Choice Intake Guidelines.
		Acronym Appendix		A number of changes were made throughout the MI Choice Waiver chapter relative to new MI Choice Intake Guidelines. Revisions to the Acronym Appendix were made as needed.
		Directory Appendix		A number of changes were made throughout the MI Choice Waiver chapter relative to new MI Choice Intake Guidelines. Revisions to the Directory Appendix were made as needed.
MSA 14-26	7/1/2014	MI Choice Waiver		A number of changes were made throughout the MI Choice Waiver chapter relative to the section 1915(c) MI Choice Waiver renewal application and the addition of the section 1915(b) MI Choice waiver initial application.
		Acronym Appendix		A number of changes were made throughout the MI Choice Waiver chapter relative to the section 1915(c) MI Choice Waiver renewal application and the addition of the section 1915(b) MI Choice waiver initial application. Revisions to the Acronym Appendix were made as needed.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Directory Appendix		A number of changes were made throughout the MI Choice Waiver chapter relative to the section 1915(c) MI Choice Waiver renewal application and the addition of the section 1915(b) MI Choice waiver initial application. Revisions to the Directory Appendix were made as needed.
		Forms Appendix		Addition of forms: • MSA-0814; MI Choice Waiver Enrollment Notification • MSA-0815; MI Choice Waiver Disenrollment Notification
MSA 14-25	7/1/2014	Medical Supplier	2.47 Wearable Cardioverter-Defibrillators	Under "Standards of Coverage", the following was inserted as the 3rd bullet point: • Have experienced a documented episode of ventricular fibrillation or sustained (lasting 30 seconds or longer) ventricular tachyarrhythmia that was not due to a transient or reversible cause and did not occur during the first 48 hours of an acute myocardial infarction; and Under "PA Requirements", 3rd paragraph, the 3rd bullet point was revised to read: • Documentation of the beneficiary's compliance with wearing the WCD. The compliance report should demonstrate a compliance rate of at least 92% for the previous 30-day period.
MSA 14-24	7/1/2014	Beneficiary Eligibility	8.2.C. Misutilization of Pharmacy Services	A 4th bullet point was added: • Utilizing multiple prescribing providers for drug categories listed in the Drug Categories subsection, including when prescribing providers provide services to the beneficiary as a private pay patient (e.g., beneficiary pays cash for office visits while using the Medicaid pharmacy benefit to obtain prescriptions).

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			8.7.B. BMP Authorized Providers	A 4th paragraph was added: MDCH reserves the right to end/terminate provider authorization for a BMP enrollee at any time. A replacement provider may be assigned following such an action. Instances will be determined on a case-by-case basis following periodic review, and must meet at least one of the following criteria: • A review of utilization reveals that a provider is not contributing to a reduction in service utilization (including use of drugs subject to abuse) as defined by the BMP; • The BMP Authorized Provider becomes a sanctioned provider; or • The BMP Authorized Provider makes referrals to the emergency department for non-emergent conditions.
MSA 14-22	5/29/2014	Healthy Michigan Plan	3.2.A. Covered Services and Limits	The 4th paragraph was revised to read: Modifier SZ must be reported in addition to …
MSA 14-21	5/29/2014	School Based Services	6.2.A. Reimbursement	In the 2nd paragraph, the bullet point list was revised to read: • Salaries [Sec. 52 & Sec. 53a] ➢ Bus Drivers ➢ Aides ➢ Employee Benefits (Bus Drivers and Aides only) • Purchased Services – Staff (Bus Drivers and Aides only) • Purchased Services – Vehicle Related Costs [Sec. 52 & Sec. 53a] ➢ Pupil Transportation by Carrier ➢ Pupil Transportation by Carrier (b/y) ➢ Family Vehicle K Cost ➢ Contracted Taxis

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				➢ Pupil Transportation Fleet Insurance ➢ Contracted/Leased Buses • Supplies [Sec. 52 & Sec. 53a] ➢ Gasoline/Fuel ➢ Oil/Grease ➢ Tires/Batteries ➢ Other Expense/Adjustments, only the costs associated with adjustments to allowable costs ➢ Bus Amortization The following text was added as a 3rd paragraph: For reimbursement purposes, Bus Aides are defined as aides who ride on the bus providing care to those students being transported, assisting with the specific health concerns documented in the student's Individualized Educational Program (IEP).
MSA 14-18	5/1/2014	Children's Special Health Care Services	Section 7 – Effective Date	Section text was re-written as follows: The effective date of CSHCS coverage is dependent upon the date of the event that medically qualifies the client for CSHCS. The CSHCS begin date is the first day of the month of this qualifying event, and may be retroactive up to six (6) months from the date MDCH receives all necessary documentation that results in a final determination of CSHCS eligibility. When application information is missing, the individual has 30 days from the date of the letter sent from MDCH requesting the missing information to submit* the information in order to preserve the initial effective date of coverage. If the information is not submitted within 30 days, the effective date of coverage may be retroactive up to six (6) months from the date the required information has been submitted. Retroactive coverage does not guarantee that providers of services already rendered will accept CSHCS payment.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				CSHCS does not reimburse families directly for payments made to providers. Individuals/families are required to provide complete and accurate information at the time of application and as circumstances change. At a minimum, changes in address and insurance must be reported as they occur. *Submission date is considered the date the document is received by CSHCS.
			8.2 Retroactive Coverage	This subsection was removed; information is included in policy in Section 7 – Effective Date. The following subsections were re-numbered.
MSA 14-16	5/1/2014	Mental Health/ Substance Abuse	Section 4 – Assertive Community Treatment Program	The section was re-written in its entirety.

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