MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 18-06

Distribution: All Providers

Issued: March 1, 2018

Subject: Updates to the Medicaid Provider Manual; MDHHS Wrap Around Code List Format Change

Effective: As Indicated

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Children's Waiver, Maternity Outpatient Medical Services, MI Choice Waiver

Updates to the Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the April 2018 update of the online version of the Medicaid Provider Manual. The manual will be available April 1, 2018 at www.michigan.gov/medicaidproviders >> Policy, Letters & 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, Letters & 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.

MDHHS Wrap Around Code List Format Change

When appropriate, MDHHS follows current Medicare Outpatient Prospective Payment System (OPPS) coverage policies. The MDHHS OPPS Wrap Around Code List provides information to providers regarding those codes covered differently than Medicare under MDHHS OPPS.

The 2nd Quarter 2018 MDHHS OPPS Wrap Around Code List, effective April 1, 2018, will be modified to a more streamlined format to facilitate code searches. The current MDHHS Wrap Around Code List, previous quarters and instructions can be found at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Outpatient Hospitals or Ambulatory Surgical Centers.

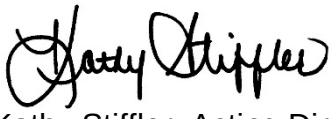
Manual Maintenance

If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy, Letters & 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 MDHHS 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 Health and Human Services, 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



Kathy Stiffler, Acting Director
Medical Services Administration

Michigan Department of Health and Human Services

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Information for the following benefit plan IDs was removed as information is now obsolete: • CMH (Community Mental Health) • MIChild (MIChild Program [CHIP]) • MIChild-D (MIChild – Dental) • SA (Substance Abuse)	Update.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.3 Assessments	Under "All Other Assessments and Testing", text was revised to read: Generally accepted professional assessments or tests, other than psychological tests, that are conducted by a mental health care professional within their scope of practice for the purposes of determining eligibility for specialty services and supports, and the treatment needs of the beneficiary. The Child and Adolescent Functional Assessment Scale (CAFAS) ~~used~~ must be used for the assessment of children 7 to 18 years of age with suspected serious emotional disturbance, and must be performed by staff who have been trained in the implementation of CAFAS. The Preschool and Early Childhood Functional Assessment Scale (PECFAS) must be used for the assessment of young children, 4 to 7 years of age, with suspected serious emotional disturbance, and must be performed by staff who have been trained in the implementation of the PECFAS. The Devereux Early Childhood Assessment (DECA) must be used for the assessment of infants and young children, 1 month to 47 months, with suspected serious emotional disturbance, and must be performed by staff who have been trained in the implementation of the DECA.	The PECFAS and the DECA assessment tools are included in the contract with CMHSPs as required for specific age groups identified (4-7 years, 1 month to 47 months, respectfully).
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.29.E. Evaluation and Outcomes Measurement	The 3rd bullet point was revised to read: • Ensure completion of the Child and Adolescent Functional Assessment Scale (CAFAS), ~~or~~ the Preschool and Early Childhood Functional Assessment Scale (PECFAS), or the Devereux Early Childhood Assessment (DECA) at intake, quarterly, and at graduation.	Inclusion of the DECA for young children as required by contract.

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

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	Selected topics were revised as follows: **Team Composition and Size** The following text was added as a 3rd 'paragraph' in the 1st column: *Telepractice is the use of telecommunications and information technologies for the provision of psychiatric services to ACT consumers and is subject to the same service provisions as psychiatric services provided in person. The telepractice modifier, 95, must be used in conjunction with ACT encounter reporting code H0039 when telepractice is used.* *All telepractice interactions shall occur through real-time interactions between the ACT consumer and the physician/nurse practitioner from their respective physical location. Psychiatric services are the only ACT services that are approved to be provided in this manner.* *Refer to the General Information for Providers Chapter of this manual for the complete Health Insurance Portability and Accountability Act (HIPPA) compliance requirements for the provision of telepractice services.*	Addition of definition for ACT telepractice.
		In the 2nd column, 1st paragraph, 3rd bullet point, the 6th sentence was revised to read: Typically, although not exclusively, physician activities may include team meetings, beneficiary appointments during regular office hours, psychiatric evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and ~~telemedicine~~ telepractice.	Clarification on provision of psychiatric services provided through telecommunications and information technologies to ACT consumers by ACT physician.
		In the 2nd column, 1st paragraph, 4th bullet point, the last sentence was revised to read: Typically, although not exclusively, nurse practitioner activities may include team meetings, beneficiary appointments during regular office hours, evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and ~~telemedicine~~ telepractice.	Clarification on provision of psychiatric services provided through telecommunications and information technologies to ACT consumers by ACT Nurse Practitioner.

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CHAPTER	SECTION	CHANGE	COMMENT
		Availability of Services The following text was added to the 1st column: *Pre-admission screens for ACT beneficiaries must be reported by including the TG modifier with the ACT encounter code of H0039.* In the 2nd column, the following text was added as the 2nd bullet point: • The ACT team is responsible for performing the required pre-admission screen for all beneficiaries enrolled in an ACT program seeking inpatient psychiatric admission.	Additional language clarifies pre-admission screen coding. Additional language clarifies ACT team responsibilities within the bundled service.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	6.4 Qualified Staff	The 1st paragraph was revised to read: Treatment services must be clinically-supervised by a psychiatrist. A psychiatrist need not be present when services are delivered, but must be available by telephone at all times. The psychiatrist ~~must~~ shall provide psychiatric evaluation or assessments at the crisis residential home or at an appropriate location in the community. A psychiatric evaluation completed by a treating psychiatrist that resulted in the admission to the program fulfills this requirement as long as the program psychiatrist has consulted with that physician as part of the admission process**.** Medication reviews performed at the crisis residential home must be performed by ~~a physician, physician's assistant or a nurse practitioner~~ appropriately licensed medical personnel acting within their scope of practice and under the clinical supervision of the psychiatrist. The covered crisis residential services (refer to Covered Services subsection) must be supervised on-site eight hours a day, Monday through Friday (and on call at all other times), by a mental health professional possessing at least a master's degree in human services and one year of experience providing services to beneficiaries with serious mental illness, or a bachelor's degree in human services and at least two years of experience providing services to beneficiaries with serious mental illness.	Language clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.E. Family Support and Training	In the last paragraph, the last bullet point was revised to read: • Parent-to-Parent Support is designed to support parents/family of children with serious emotional disturbance or intellectual/developmental disabilities, including autism, as part of the treatment process to be empowered, confident and have knowledge and skills that will enable the parent/family to improve their child's and family's ~~them to assist their child to improve in~~ functioning. Utilizing their lived experience, the trained parent support partner, who has or had a child with special mental health needs, provides education, coaching, ~~training,~~ and support and enhances ~~augments~~ the assessment and mental health treatment process. The parent support partner provides these services to the parents/caregivers ~~and their family~~. These activities are provided in the home and in the community. The parent support partner is an active member of the treatment team and participates in team consultation with the treating professionals. The parent support partner is to be provided regular supervision ~~and team consultation by the treating professionals~~.	Update to assist with clarifying service.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.K. Support and Service Coordination	In the last paragraph (table), text in the 2nd line, 1st column, was revised to read: Qualifications of Supports Coordinator Assistants ~~and Services~~ and Independent Services and Supports Brokers	Correction.

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CHAPTER	SECTION	CHANGE	COMMENT
Healthy Michigan Plan	5.6.B.4. Crisis Services	Under "Crisis Residential Services", 4th bullet point, the 1st paragraph was revised to read: **Qualified Staff:** Treatment services must be clinically supervised by a psychiatrist. A psychiatrist need not be present when services are delivered but must be available by telephone at all times. The psychiatrist ~~must~~ shall provide psychiatric evaluation or assessments at the crisis residential home or at an appropriate location in the community. A psychiatric evaluation completed by a treating psychiatrist that resulted in the admission to the program fulfills this requirement as long as the program psychiatrist has consulted with that physician as part of the admission process**.** Medication reviews performed at the crisis residential home must be performed by ~~a physician, physician assistant or a nurse practitioner~~ appropriately licensed medical personnel acting within their scope of practice and under the clinical supervision of the psychiatrist. The covered crisis residential services must be supervised on-site eight hours a day, Monday through Friday (and on call at all other times). Supervision must be by a behavioral health professional (Mental Health Professional [MHP] and/or a Substance Abuse Treatment Specialist [SATS] depending on the scope of services being provided) possessing at least a master's degree in human services and one year of experience providing behavioral health services to individuals with serious mental illness and/or substance use disorders; or a bachelor's degree in human services and at least two years of experience providing behavioral health services to individuals with serious mental illness and/or substance use disorders.	
Home and Community Based Services	3.1.A.8. Accessibility	Text was revised to read: Each setting must be physically accessible to the individuals residing there so the individuals may function as independently as they wish. Individuals must be able to move around in the setting without physical barriers getting in their way. This is especially true for individuals ~~in~~ utilizing wheelchairs or who require walking aids. Furniture must be placed in such a way that individuals can easily move around it, with pathways large enough for a wheelchair, scooter or ~~walker~~ walking aids to navigate easily if individuals with these types of mobility aids reside in the setting.	Correction.

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Home and Community Based Services	3.2 Settings Not Compliant With the HCBS Final Rule Requirements	The last bullet point was revised to read: • Other locations that have characteristics of an institution (e.g., Child Caring Institutions)	Clarification.
Home Health	9.1 Home Help Program	Text was revised to read: The Home Help Program provides unskilled personal care services (i.e., assistance with ADLs, IADLs, and other services allowed by the Home Help Program ~~e.g., laundry, housekeeping, snow removal, and other personal care tasks~~) to assist eligible beneficiaries who are blind, disabled, or otherwise functionally limited. The beneficiary's adult services worker at the local MDHHS office arranges for these services with the personal care provider. The Home Help POC must clearly identify why the HHA services are required along with Home Help. Medicaid covers occasional follow-up HHA visits made to observe, evaluate and document the beneficiary's progress if ordered by the attending physician.	Provider clarification.
Hospital Reimbursement Appendix	7.4 Calculation of DSH Ceiling	In the last paragraph, the 3rd sentence was revised to read: An ~~percentage~~ increase based on the difference between the audited ceiling and Interim ceiling from the most recent available year will then be applied to the current Interim DSH ceiling calculation.	
Maternal Infant Health Program	1.2 Staff Credentials	In the 2nd paragraph, under "Infant Mental Health Specialist", the 2nd bullet point was revised to read: • Infant Mental Health Endorsement by the Michigan Association for Infant Mental Health (MI-AIMH), ~~level 2 or level 3 ;~~ demonstrating competency at the Infant Mental Health Specialist level; and	Update to reflect changes in MI-AIMH endorsement provisions.
Non-Emergency Medical Transportation	Section 2 – Common Terms	The following terms/definitions were added: **Round Trip:** When a beneficiary is transported from their residence, or another location, to a Medicaid-covered service and then returned to their original point of origin. **Trip:** One-way transportation of a beneficiary from their residence, or another location, to a Medicaid-covered service.	

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Nursing Facility Cost Reporting & Reimbursement Appendix	10.5 Variable Cost Component (VCC) – Class I and Class III Facilities	In the 2nd paragraph, the 1st sentence was revised to read: For Class I and Class III nursing facility rate setting periods beginning on or after October 1, ~~2016~~ 2003, the Variable Cost Component is a per resident day rate and is equal to the lesser of the facility's Variable Rate Base (VRB) or the Class Variable Cost Limit (VCL), plus the Economic Inflationary Update (EIU).	Correction.
Practitioner	3.3.A. Newborn Hearing Screening Examination	The last paragraph was revised to read: If the hospital is not equipped for ABR or EOAE, the child's physician, CNM, or NP must refer the newborn to a Medicaid enrolled hearing center ~~for~~ where screening must be completed prior to one month of age. The following text was added: Refer to the Hearing Services subsection of the Hospital Chapter for additional information.	Add and remove text to align with wording in the Hospital Chapter.
Practitioner	3.3.B. Local Health Department Screenings	Text was revised to read: The primary care provider or Head Start agency (with approval from the child's primary care provider) may refer preschool-aged children to the local health department (LHD) for objective hearing screening. The results of the screening must be reported to the child's primary care provider. If the LHD is unable to report the results to the child's primary care provider, the LHD must clearly document why this was not accomplished. The results must also be shared with the Head Start agency if that agency was the referral source. MDHHS monitors the number of MHP referrals reported by LHDs, and may initiate charge-backs to the plans. Refer to the Additional Information on Objective Hearing & Vision Screening subsection of the Local Health Department Chapter for additional information.	Add text to align with Local Health Department Chapter.

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Practitioner	3.18 Supplies in the Office Setting	Text was revised to read: ~~Medicaid separately covers a limited number of supplies used in the office setting.~~ RVU-based payment to practitioners includes payment for the office overhead expense associated with the service. In most cases, the overhead includes the supplies used or provided by the practitioner in connection with the service, and the supplies are not separately reimbursed. Providers must not require beneficiaries to ~~buy~~ purchase an ~~supply~~ item in advance from a pharmacy or ~~other~~ medical supplier that is an integral component of the service. ~~necessary to use in providing the service. If a beneficiary needs supplies to use in the home, providers should write a prescription that the beneficiary can take to a pharmacy or medical supplier to be filled. Medicaid does not cover take-home supplies for the office setting. Any~~ Surgical dressings applied by a physician in the office or other non-facility setting are not covered separately. Medicaid does not cover take-home supplies dispensed from the office setting. If a beneficiary requires in-home supplies, a written prescription must be presented to the pharmacy or medical supplier and supplies dispensed accordingly. In keeping with the RVU-based fee schedule, Medicaid separately covers a limited number of supplies used in the office setting (such as intrauterine devices and casting supplies) because an allowance for these supplies is not typically included in the respective treatment procedure codes. Casting and splinting supplies are covered separately ~~in the office setting~~ when used with the fracture and dislocation or casting, splinting or strapping procedure codes listed in the musculoskeletal surgery section of the CPT coding manual. ~~An allowance for these supplies is not included in these treatment codes. Cast/splint supplies are not covered without the appropriate fracture/dislocation codes.~~ ~~The following supplies are covered separately when provided in the office setting:~~ • ~~Implantable external access device~~ • ~~Levonorgestrel implant (is payable in addition to the insertion procedure on the same day)~~	

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		~~• Progestasert IUD or copper IUD (is payable in addition to the insertion of the device on the same day)~~ • ~~Levulan PDT~~ (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding ~~specific~~ separately covered supplies ~~which are covered separately~~.)	
Practitioner	Section 21 – Physical Therapist	The following text was added as a 3rd paragraph: Refer to the Outpatient Therapy Chapter for additional therapy information.	Text added to point to the Outpatient Therapy Chapter for more comprehensive therapy information.
Practitioner – Reimbursement Appendix	2.2 Payment Adjustment Amount	In the 1st paragraph, the 2nd bullet point was revised to read: • ~~95.7%~~ Up to 100% of the Average Commercial Rate for the service rendered. In the 2nd paragraph, the 2nd bullet point was revised to read: • The difference between the total of the Medicaid, Medicare, and commercial insurance payments and ~~95.7%~~ up to 100% of the Average Commercial Rate.	Update.
Acronym Appendix		Addition of: DECA – Devereux Early Childhood Assessment PECFAS – Preschool and Early Childhood Functional Assessment Scale	Update.
Directory Appendix	Pharmacy Resources	Under "List of Rebate-Participating Labelers", the website address was revised to read: https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html	Update.

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Forms Appendix	MSA-0732; Private Duty Nursing Prior Authorization – Request for Services	For form completion instructions, the 2nd and 3rd paragraphs were revised to read: MDHHS requests that the MSA-0732 be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & ~~and~~ Forms >> Forms. This form must be used to request Prior Authorization (PA) for Private Duty Nursing (PDN) services for beneficiaries with Medicaid coverage under 21 years of age. ~~**with the exception of those enrolled in the Children's Waiver or the Habilitation Supports Waiver.**~~ Private Duty Nursing is not a benefit under Children's Special Health Care Services (CSHCS). Beneficiaries with CSHCS coverage may be eligible for PDN under Medicaid. A request to begin services may be submitted by a person other than the PDN such as the hospital Discharge Planner, CSHCS case manager, physician, or physician's staff person. When this is the case, the person submitting the request must do so in consultation with the PDN who will be assuming responsibility for the care of the beneficiary. If services are being requested for more than one beneficiary in the home, a separate form must be completed for each beneficiary.	

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MSA 17-31	9/1/2017	Home and Community Based Services	3.7 New Providers (new subsection; following subsection was re-numbered)	New subsection text reads: Effective October 1, 2017, any new HCBS provider and their provider network must be in immediate compliance with the federal HCBS Final Rule in order to render services to Medicaid beneficiaries. This requirement does not apply to existing providers and their provider networks who rendered HCBS to Medicaid beneficiaries before the effective date of this requirement. The Michigan Department of Health and Human Services (MDHHS) will continue to work with existing providers towards coming into compliance with the federal HCBS Final Rule as specified in the State Transition Plan. In order to comply with the federal HCBS Final Rule, new providers must: • Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint; • Enhance independence; • Enhance independence in making life choices; • Enable choice regarding services and who provides them; and • Ensure that the setting is integrated in, and supports full access to, the greater community.

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				New residential providers must demonstrate that services are delivered within a setting affording the beneficiary sufficient opportunity and choice to engage with the broader community by ensuring that the: • Setting is selected by the individual from among setting options; • Individual has a lease or other legally enforceable agreement providing similar protection; • Individual has privacy in his/her unit, including lockable doors; • Individual has a choice of roommates (if applicable) and freedom to furnish or decorate the unit; • Individual controls his/her own schedule, including access to food at any time; • Individual can have visitors at any time; and • Setting is physically accessible. New non-residential providers must demonstrate that services are delivered within a setting affording the beneficiary sufficient opportunity and choice to engage with the broader community by ensuring that the setting: • Does not isolate the individual from the broader community; and • Is not institutional in nature or has the characteristics of an institution.
MSA 17-35	11/1/2017	Program of All-Inclusive Care for the Elderly	Section 4 – PACE Organization Evaluation Criteria	Section was re-formatted to include subsections. Text was relocated to subsection 4.1.

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			4.1 Initial Applications (new subsection)	Text was relocated from Section 4 and was revised to read: A prospective PACE organization ~~must~~ can be a not-for-profit or for profit private or public entity that is primarily engaged in providing PACE services and participates in both Medicare and Medicaid. Michigan licensure as a health care entity is not required; however, unlicensed entities may only serve Medicare and Medicaid beneficiaries. Federal regulations (42 CFR Part 460) describe administrative requirements for PACE. At a minimum, prospective entities must meet the federal requirements for PACE organizations, enroll as a Michigan Medicaid provider, and complete a feasibility study. MDHHS will evaluate potential PACE organizations using the following criteria: • Submission of a feasibility study that: ➢ identifies the proposed service area; ➢ shows evidence of demand for PACE services in the proposed service area (the potential pool of PACE beneficiaries should be sufficient to have 250 to 300 beneficiaries enrolled within four to five years of start-up); ➢ identifies competing PACE organizations, documents the organization's timeline for development and anticipated costs; ➢ identifies the anticipated source of referrals for potential beneficiaries; and ➢ assesses the supply of alternative long-term care services already in existence in the community. If MDHHS receives multiple letters of intent for the same service area, the feasibility studies will be reviewed in the order in which they are received. • Organizational commitment to principles consistent with the PACE model. • Evidence of experience in providing primary, acute and/or long-term care services to the target population and evidence of positive community support.

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				• Evidence that the organization has the depth in leadership and experience required to develop and implement PACE successfully. • Evidence that the PACE organization will either be cost neutral or save money for long term care services provided by MDHHS in the PACE organization's service area (i.e., total Medicaid expenditures for services in the service area will not increase and may decrease). • Assurance of adequate financial capacity to fund program development and start-up costs, including identification of patient capacity and break-even consideration. • Evidence of the proposed provider network and assurance that the organization will have staff and professionals experienced in providing care to the target population. • Evidence that the Executive (Program) Director position will be staffed with a full-time employee. • Evidence that the key positions of Medical Director, Center Manager, Financial Manager, and Quality Improvement Manager are sufficiently staffed, as determined by MDHHS, to meet the needs of the PACE organization. • Ability to meet federal PACE requirements. A prospective PACE program must submit to MDHHS: • Feasibility Study: within 90 calendar days of submitting their letter of intent. • Provider Application: within one year of MDHHS approval of the feasibility study. Other evaluation criteria may be considered and will be available to organizations who file a letter of intent with MDHHS to become a PACE organization.
			4.2 Expansion Applications (new subsection)	New subsection text reads: Expansion applications will not be accepted by MDHHS until the first CMS audit has been completed with good standing and the organization is fiscally sound.

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			4.3 Alternative Care Settings (new subsection)	New subsection text reads: To be eligible to request an ACS, the following guidelines must be met: • The PACE organization must have successfully completed their first trial period audit and be in good standing with CMS, per CMS audits. • An ACS participant must belong to a PACE organizations center. • The PACE organization's enrollment limit must have adequate space to accommodate projected ACS attendants. • MDHHS must tour the proposed ACS location prior to approval. • The ACS must be less than one (1) hour travel time from PACE Center. The ACS is subject to MDHHS Readiness Review and will be included in the PACE organization's annual audits. ACSs are also subject to all state and federal regulations.

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				The following documents must be submitted to MDHHS when an ACS is requested: • Previous year's annual financial report for the PACE organization; • The PACE organization's business plan for ACS; • Financial projection for ACS site (to include cost of ACS site, renovations, staff, equipment, etc.); • Description of what population of participants will attend the ACS; • Description of what and how services will be provided at the ACS: ➢ ACS services must include, but are not limited to, meals, activities, personal care, laundry, and nursing (triage); • Description of how services that are not provided at the ACS will be available to participants; and • Description of plan for participants to attend a PACE Center, at least quarterly or more often, as determined by the PACE organization interdisciplinary team. MDHHS may request additional information when necessary.
MSA 17-42	11/27/2017	Medicaid Provider Manual Overview	1.1 Organization	Addition of: Chapter Title: Home and Community Based Services Affected Providers: Integrated Care Organizations (ICOs), Prepaid Inpatient Health Plans (PIHPs), and Waiver Agencies Chapter Content: Coverage policy related to the requirements for Home and Community-Based Services (HCBS)
		Home and Community Based Services		Addition of new chapter.

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MSA 17-43	11/27/2017	Practitioner Reimbursement Appendix	Section 3 – Primary Care Practitioner Services Incentive Payment	Text was revised to read: For dates of service on and after January 1, 2015, MDHHS applies an increased payment rate to enrolled providers for primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine and, for dates of service on and after January 1, 2018, physicians with the specialty designation of general practice. The increase applies to a set of designated primary care services.
			3.1 Provider Eligibility	In the 1st paragraph, the 1st sentence was revised to read: Physicians with primary specialty designations of family medicine, general internal medicine, ~~and~~ pediatric medicine, and general practice may qualify as primary care practitioners for purposes of increased payment. In the 3rd paragraph, the 1st, 2nd, and 3rd bullet points were revised to read: • Board Certification: A primary care physician who has designated their primary specialty in their CHAMPS enrollment file as one of the ~~three~~ eligible specialties and has provided applicable Board certification information will be validated by MDHHS prior to any enhanced payment.

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				• Board Eligible: A primary care physician who has designated their primary specialty in their CHAMPS enrollment file as one of the ~~three~~ eligible specialties and has provided applicable documentation to support board eligibility status is also eligible for the enhanced payment. MDHHS will recognize physicians as board eligible for the period of time as defined by the applicable medical board following completion of their medical residency training program in one of the defined specialties. • Review of Practice Characteristics: For non-board certified or non-board eligible primary care physicians, MDHHS will review an enrolled practitioner's billing history for the previous calendar year. At least 60 percent of the physician's codes paid by Medicaid must be for the evaluation and management (E/M) codes specified in this policy, including the preventive medicine E/M codes. This review of practice characteristics will be done by MDHHS only for providers who have self-attested by designating in their CHAMPS enrollment file that their primary specialty is one of the ~~three~~ eligible specialties. The last paragraph was revised to read: Physicians with primary specialty designations of family medicine, general internal medicine, ~~and~~ pediatric medicine, and general practice who are affiliated with Medicaid Health Plans (MHP) are eligible for the primary care practitioner rate increase as identified by their Primary Care Provider status within the MHP network.

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MSA 17-48	11/27/2017	General Information for Providers	Section 2 – Provider Enrollment	The 2nd paragraph was revised to read: Any individual or entity that provides services to, or orders, prescribes, refers or certifies eligibility for services for, individuals who are eligible for medical assistance under the Medicaid State Plan is required to be screened and enrolled in Medicaid. Providers ~~(except managed care organizations)~~ must have their enrollment approved through the on-line MDHHS CHAMPS Provider Enrollment (PE) subsystem to be reimbursed for covered services rendered to eligible Medicaid beneficiaries. Enrollment in CHAMPS neither requires nor mandates those providers who are part of a managed care network to accept Medicaid Fee-for-Service beneficiaries. Refer to the Directory Appendix for contact information related to the online application process, including a CHAMPS Preparation Checklist of required information. The 6th paragraph was deleted. ~~Managed Care Organizations must complete their enrollment process through their MDHHS Contract Manager.~~
MSA 17-34	12/1/2017	Early and Periodic Screening, Diagnosis and Treatment	5.1 Vision Screening	Text was revised to read: PCPs ~~must~~ are to perform a subjective vision screening (i.e., by history) or risk assessment at each well child visit as recommended by the AAP periodicity schedule. For asymptomatic children 3 years of age and older, an objective screening must occur as indicated on the AAP periodicity schedule. ~~For children of any age, referral to an optometrist or ophthalmologist must be made if there are symptoms or other medical justification (e.g., parent/guardian has suspicions about poor vision in the child). The AAP requires a vision risk assessment at each well child visit.~~ An objective vision screening is accomplished using a standardized screening tool. A visual acuity screen is recommended at 4 and 5 years of age, as well as in cooperative children 3 years of age. Instrument-based screening may be used to assess risk at 12 and 24 months of age, in addition to the well child visits at 3 through 5 years of age. MDHHS requires vision testing at specific well child visits for children 3 years of age and older.

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			5.1.A. Preschool	Text was revised to read: ~~Due to behavior and comprehension ability of children younger than 3 years of age, the standard screening is subjective. An objective screening should begin at 3 years of age.~~ An objective vision screening ~~is accomplished using a standardized screening tool and~~ may be performed on Medicaid eligible preschool age children each year beginning at 3 years of age through 6 years of age by qualified Local Health Department (LHD) staff. If the child is uncooperative, the screening should be re-administered within six months. LHDs may provide objective vision screening services and accept referrals for screening from the PCP and from Head Start agencies. In an effort to promote communication with the child's medical home, the objective vision screening results must be reported to the child's PCP. In the event the LHD is unable to report the objective vision screening results to the child's PCP, the LHD must clearly document why this could not be accomplished. If the LHD receives authorization, the results may be shared with the Head Start agency if that agency was the referral source.
			5.1.B. School Age	Subsection was deleted. (Information was incorporated into 5.1.) ~~A subjective vision screening must be performed at each well child visit; an objective screening shall be performed as indicated on the AAP periodicity schedule.~~
			5.1.B. Referral (new subsection)	New subsection text reads: For children of any age, referral to an optometrist or ophthalmologist should be made if there are symptoms or other medical justification (e.g., parent/guardian has suspicions about poor vision in the child). A routine eye examination by an optometrist or ophthalmologist once every two years is a Medicaid benefit and does not require prior authorization.

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			5.1.C. Periodicity Schedule for Vision Screening	Subsection was deleted. ~~A vision screening is to be performed at 3, 4, 5, 6, 8, 10, 12, 15, and 18 years of age. A risk assessment is to be performed, with appropriate action to follow if positive, for newborns and during the ages of:~~ ~~3 to 5 days~~, ~~1 month~~, ~~2 months~~, ~~4 months~~, ~~6 months~~, ~~9 months~~, ~~12 months~~, ~~15 months~~, ~~18 months~~, ~~24 months~~, ~~30 months~~, ~~7 years~~, ~~9 years~~, ~~11 year~~, ~~13 years~~, ~~14 years~~, ~~16 year~~, ~~17 years~~, ~~19 years~~, ~~20 years~~
			5.2 Hearing Screenings	Text was revised to read: Providers ~~must~~ are to perform a subjective hearing screening (i.e., by history) or risk assessment at each well child visit as recommended by the AAP periodicity schedule. For asymptomatic children ~~4 years of age and older~~, an objective screening must occur as indicated on the AAP periodicity schedule. ~~The AAP requires a hearing risk assessment at each well child visit.~~ Screen the child with audiometry, including 6,000 and 8,000 Hz high frequencies, once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. Confirm the initial screen was completed, verify the results as soon as possible, and follow-up as appropriate.
			5.2.B. Preschool	The 1st sentence was removed. ~~A subjective hearing screening (i.e., by history) must be performed at each well child visit.~~

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			5.2.C. School Age	Subsection was deleted. ~~A subjective hearing screening (i.e., by history) must be performed at each well child visit. Children with symptoms or risk factors should be referred to a hearing center, audiologist, otologist, or CSHCS-sponsored otology clinic at a LHD for further objective testing or diagnosis.~~
			5.2.C. Referral (new subsection)	New subsection text reads: A referral to a hearing center, audiologist, otologist, or CSHCS-sponsored otology clinic at a LHD should be made if there are symptoms (e.g., parent/guardian has suspicions about poor hearing in the child), risk factors (e.g., exposure to ototoxic medications, family history of hearing deficits), or other medical justification for further objective testing or diagnosis.
			5.2.D. All Ages	Subsection was deleted. ~~For children of any age, a subjective hearing screening (i.e., by history) must be performed at each well child visit. A referral to a hearing center, audiologist, otologist, or CSHCS-sponsored otology clinic at a LHD should be made if there are symptoms (e.g., parent/guardian has suspicions about poor hearing in the child), risk factors (e.g., exposure to ototoxic medications, family history of hearing deficits), or other medical justification.~~

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			5.2.E. Periodicity Schedule for Hearing Screening	Subsection was deleted. ~~A hearing screening is to be performed for newborns and during 4, 5, 6, 8, and 10 years of age. A risk assessment is to be performed, with appropriate action to follow if positive, within 3 to 5 days of birth and during the ages of:~~ ~~1 month~~, ~~2 months~~, ~~4 months~~, ~~6 months~~, ~~9 months~~, ~~12 months~~, ~~15 months~~, ~~18 months~~, ~~24 months~~, ~~30 months~~, ~~3 years~~, ~~7 years~~, ~~9 years~~, ~~11 years~~, ~~12 years~~, ~~13 years~~, ~~14 years~~, ~~15 years~~, ~~16 years~~, ~~17 years~~, ~~18 years~~, ~~19 years~~, ~~20 years~~
			6.4 Psychosocial/Behavioral Assessment	Text was revised to read: Children should be observed to detect psychosocial and behavior issues. A psychosocial/behavioral assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. A psychosocial/behavioral assessment should occur during every well child visit and ...
			6.6 Depression Screening	The 1st sentence was revised to read: A depression screening is to be performed annually for all children and adolescents who are ~~11~~ 12 years of age and older as indicated by the AAP periodicity schedule.

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			6.7 Maternal Depression Screening (new subsection)	New subsection text reads: Screening for maternal depression with a screening tool, such as the Edinburgh scale, is to be performed by the infant's PCP as recommended by the AAP periodicity schedule. It is intended that the service should be reported and billed under the infant's Medicaid ID number using the appropriate Current Procedural Terminology (CPT) code as it is a service rendered for the benefit of the infant. If the screening is positive, the PCP should address the mother-child dyad relationship (attachment and bonding), follow-up, and refer as appropriate.
			9.2 Newborn Bilirubin (new subsection; following subsections were re-numbered)	New subsection text reads: A universal predischarge newborn bilirubin screening (measurement and assessment of clinical risk factors) is to be performed using total serum bilirubin (TSB) or transcutaneous bilirubin (TcB) measurements to evaluate the risk of subsequent severe hyperbilirubinemia as recommended by the AAP periodicity schedule. The PCP should confirm initial screening was accomplished, verify the results, and follow-up as appropriate.

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			9.8 Sexually Transmitted Infections (STI)/Human Immunodeficiency Virus (HIV) Screening	The subsection was re-numbered as 9.9 due to addition of earlier subsection. The subsection title was revised to read: Sexually Transmitted Infections (STI)~~/Human Immunodeficiency Virus (HIV) Screening~~ Text was revised to read: ~~All sexually active individuals must be screened for sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) according to the AAP periodicity schedule. A routine HIV screening should be offered to all individuals at least one time between 16 to 18 years of age. Individuals at high risk should be tested yearly. HIV infected individuals should be referred to, and cared for, by providers with expertise in HIV medicine.~~ A risk assessment for sexually transmitted infections (STIs) is to be performed annually for all sexually active individuals beginning at 11 years of age as recommended by the AAP periodicity schedule. Adolescents and children should be fully immunized, screened for risk, and appropriately tested and treated for STIs. It is recommended to screen males who have sex with males (MSM) at least annually for STIs, and screen every three to six months if the male adolescent is considered high risk because of multiple or anonymous partners, having sex in conjunction with illicit drug use, or having sex partners who participate in these activities.

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			9.10 Human Immunodeficiency Virus (HIV) Screening (new subsection; following subsections were re-numbered)	New subsection text reads: A risk assessment for the human immunodeficiency virus (HIV) is to be performed annually for children beginning at 11 years of age and as recommended by the AAP periodicity schedule. A routine HIV screening should be offered to all individuals at least one time between 15 and 18 years of age, making every effort to preserve confidentiality of the adolescent. Youth at increased risk of HIV infection (including those who are sexually active, participate in injection drug use, or are being tested for other STIs) should be tested for HIV and reassessed annually. The PCP should verify the results, follow-up, and refer as appropriate.
			Section 10 – Oral Health	Text was revised to read: The dental health of the beneficiary begins with an oral health screening and caries risk assessment by the child's PCP ~~and should be administered according to~~ for beneficiaries at each well child visit as recommended by the AAP periodicity schedule. The oral cavity must be inspected at each well child visit regardless of whether teeth have erupted or not. MDHHS requires providers to stress the importance of preventive and restorative dental care. Encourage parents/caregivers to brush their child's teeth as soon as teeth erupt with fluoride toothpaste in the proper dosage appropriate for the child's age. Children should be referred to establish a dental home when the first tooth erupts and as recommended by the AAP periodicity schedule. Communication between the dental and medical homes should be ongoing to appropriately coordinate care for the child. If a dental home is not available, the PCP should continue to perform an oral health risk assessment during each well-child visit. The PCP should follow-up, educate, and refer as appropriate. Refer to the Directory Appendix for website information on the American Academy of Pediatric Dentistry (AAPD) Caries Risk Assessment Tool. A separate periodicity schedule for dentists is established. The Dental Periodicity Schedule follows the AAPD Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling schedule. Refer to the Dental chapter of the Medicaid Provider Manual for additional information. ~~and adhere to the following:~~

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				• ~~The oral cavity must be inspected at each well child visit regardless of whether teeth have erupted or not.~~ • ~~Each child should receive an oral health risk assessment by 6 months of age by a qualified pediatrician or a qualified pediatric health care professional. It is recommended that a child should have a dental home established by 1 year of age.~~ • ~~Beginning at 3 years of age (younger if the individual child exhibits needs), a child should visit a dentist every six months for examination, prophylaxis, and other preventive care. If the child does not have their next preventive care dental appointment scheduled, the provider must make a referral. When restorative dental care is needed, the child must be referred for treatment.~~ • ~~A separate periodicity schedule for dentists is established.~~

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			10.1 Oral Health Screen and Fluoride Varnish	The subsection title was revised to read: ~~Oral Health Screen and~~ Fluoride Varnish Text was revised to read: ~~Providers should complete an oral health screening and caries risk assessment for beneficiaries under 21 years of age at intervals indicated by the Dental Periodicity Schedule. (Refer to the Directory Appendix for website information on the American Academy of Pediatric Dentistry (AAPD) Caries Risk Assessment Tool.) Children who have been determined to be at risk of development of dental caries or who fall into recognized risk groups should be directed to establish a dental home when the first tooth erupts or no later than 12 months of age.~~ ~~As an oral health intervention, providers should apply fluoride varnish to high risk children from birth to 35 months of age up to four times in a 12 month time period. Providers must complete the online Children's Oral Health training modules and obtain certification prior to providing oral health screenings and fluoride varnish applications. Providers who complete the certification requirements are allowed to bill Medicaid for these services. Specific certification requirements are available on the MDHHS Oral Health website. (Refer to the Directory Appendix for website information.)~~

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				Providers should apply fluoride varnish as recommended by the AAP periodicity schedule. Fluoride varnish should be applied to the teeth of all infants and children under the delegation and supervision of the PCP when the first tooth erupts until establishment of a dental home as recommended by the AAP periodicity schedule. The AAP recommends that providers receive additional training on oral screenings, fluoride varnish indications and application, and office implementation. Providers and staff are encouraged to complete the online Children's Oral Health Smiles for Life Course 6: Caries Risk Assessment, Fluoride Varnish and Counseling training module and obtain certification prior to providing oral health screenings and fluoride varnish applications. (Refer to the Directory Appendix for website information.)
			10.2 Periodicity Schedule for Dental Providers	Subsection was deleted. ~~The Dental Periodicity Schedule follows the AAPD Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling schedule. The guidelines recommend that a child have a first dental visit when the first tooth erupts or no later than 12 months of age. The examination is to be repeated every six months or as indicated by the child's risk status and susceptibility to disease.~~
			10.2 Fluoride Supplementation (new subsection)	New subsection text reads: The PCP should consider oral fluoride supplementation as recommended by the AAP periodicity schedule if the primary water source is deficient in fluoride. It is important to consider a child's overall systemic exposure to fluoride from multiple sources (e.g., water fluoridation, toothpaste, supplements, and/or varnish) prior to prescribing fluoride supplements to minimize the risk of mild fluorosis.

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		Directory Appendix	Provider Resources	Under "American Academy of Pediatrics (AAP)", the 1st category of information was revised to read: Website: ~~http://brightfutures.aap.org >> Bright Futures/AAP Periodicity Schedule~~ www.aap.org >> About the AAP >> Committees, Councils & Sections >> Section Websites >> Oral Health >> Resources Information Available/Purpose: ~~Recommendations for Preventive Pediatric Health Care/Periodicity Schedule~~ Oral health resources
			Provider Resources	Addition of: Contact/Topic: MDHHS Oral Health Program Mailing/Email/Web Address: Email: OralHealth@michigan.gov Web Address: www.michigan.gov/oralhealth Information Available/Purpose: Education and technical assistance on oral health resources regarding oral screenings, caries risk assessment, and fluoride varnish applications.

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			Provider Resources	Under "Smiles for Life", text was revised as follows: Information Available/Purpose: Comprehensive oral health curriculum designed to enhance the role of primary care clinicians in promoting oral health. ~~Providers will need to submit certification of completion of Module 6 – Fluoride Varnish to the MDHHS Oral Health Program before billing Medicaid for oral screenings and fluoride varnish applications.~~ Providers and staff are encouraged to complete the online Children's Oral Health Smiles for Life Course 6: Caries Risk Assessment, Fluoride Varnish and Counseling training module at www.smilesforlifeoralhealth.org and obtain certification prior to providing oral health screenings and fluoride varnish applications.

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MSA 17-36	12/1/2017	General Information for Providers	1.3 File Transfer (new subsection; following subsections were re-numbered)	New subsection text reads: The MDHHS–File Transfer application allows for the secure electronic transfer of files between MDHHS and Medicaid providers, Medicaid Health Plans, and other organizations. This application is a front-end interface for secure file transfer protocol (FTP) functionality, is Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant, and uses 128-bit encryption. File types for transfer include, but are not limited to, Medicaid cost report software, Medicaid filed cost reports, Medicaid filed reconciliation reports, and claim and encounter files containing protected health information. All users requesting access to the MDHHS–File Transfer application must have their own unique MILogin user identification (ID) and password, and the user ID and password must not be shared. Each approved user must be authorized to view any sensitive data that may be transmitted. MDHHS program areas that use the MDHHS–File Transfer application to securely communicate with providers are authorized to limit the number of users per organization. MDHHS may contact the requestor directly to collect additional information regarding the users that will be applying, the area type(s) they need access to (shared and/or provider specific), and when user access should be removed. MDHHS is not responsible for communications that are undeliverable or are otherwise not received due to a provider's or authorized user's failure to maintain or provide accurate information. MDHHS-File Transfer is accessed through MILogin. Refer to the Directory Appendix for website information.

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		Directory Appendix	Provider Resources	Addition of: Contact/Topic: MDHHS-File Transfer Phone # Fax #: Client Service Center = 1-800-968-2644 Mailing/Email/Web Address: Log into MDHHS-File Transfer using MILogin: https://milogintp.michigan.gov Assistance with MILogin can be found online at www.michigan.gov/mdhhs-milogin-info
MSA 17-41	12/1/2017	Maternal Infant Health Program	Section 2 – Program Components	The last paragraph was deleted. ~~On the rare occasion when the Risk Identifier does not indicate the need for MIHP services but professional observation suggests the beneficiary would benefit from MIHP services, the MIHP provider must obtain written authorization from the MIHP consultant to proceed with MIHP services for FFS beneficiaries. MHPs may require prior authorization to proceed with MIHP services to MHP enrollees. Documentation must support how the beneficiary may benefit from MIHP services.~~
			2.2 Infant Risk Identifier	The 5th paragraph was deleted. ~~The goal of the MIHP is to promote healthy infant growth and development. Screening tools and educational materials utilized by the MIHP are designed for use with infants. For this reason, if risks are identified that may necessitate a Risk Identifier for a child older than 12 months of age or a MIHP professional visit beyond 18 months of age, the MIHP provider must obtain written authorization from the MIHP consultant prior to the visit for all FFS beneficiaries. MHPs may require prior authorization for MHP enrollees.~~

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			2.18 Authorization for Program Exceptions (new subsection)	New subsection text reads: In limited situations, when beneficiary needs surpass outlined MIHP program parameters, MIHP consultants may recommend additional visits for MIHP services, as required, in the following circumstances: • Initiation of services for a child over 12 months of age; • Continuation of services beyond 18 months of age; and • Professional observation indicating that a beneficiary will benefit from MIHP services after being assessed with no risks using the appropriate program assessment tool (Risk Identifier). MIHP providers seeking program exceptions for all beneficiaries must submit documentation to their assigned MIHP consultant that supports any identified risks and how the beneficiary may benefit from services. As a reminder, program screening tools and educational materials utilized by the MIHP are designed for maternal and infant use only. MIHP consultants will be responsible for direct authorization of program exceptions for FFS beneficiaries. For beneficiaries enrolled in MHPs, the MIHP consultants will recommend exception visits to the MHPs. MHPs will be responsible for the review and processing of the prior authorization request for the services in accordance with their utilization management processes. All approved written authorizations are to be kept in the beneficiary's MIHP provider file and must be available upon request. Additionally, as applicable, the MIHP provider is required to note any granted authorizations in the program approved communication tool for a beneficiary enrolled in a Medicaid Health Plan.
MSA 17-45	12/1/2017	Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.G.1. Peer Specialist Services	Subsection was re-numbered as 17.3.G.**2.**
			17.3.G.2. Drop-In Centers	Subsection was re-numbered as 17.3.G.**1.**

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			17.3.G.3. Peer Recovery Coach Services (new subsection)	New subsection text reads: **Peer Recovery Coach Services** Peer Recovery Coach services are provided by a person in a journey of recovery from addictions or co-occurring disorders who identifies with a beneficiary based on a shared background and life experience. The Peer Recovery Coach serves as a personal guide and mentor for beneficiaries seeking, or already in, recovery from substance use disorders. Peer Recovery Coaches support a beneficiary's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports while role modeling the many pathways to recovery as each individual determines his or her own way. The Peer Recovery Coach helps to remove barriers and obstacles, and links the beneficiary to resources in the recovery community. Services provided by a Peer Recovery Coach support beneficiaries to become and stay engaged in the recovery process and reduce the likelihood of relapse. Activities are targeted to beneficiaries at all places along the path to recovery, including outreach for persons who are still active in their addiction, up to and including individuals who have been in recovery for several years. Peer Recovery Coaches embody a powerful message of hope, helping beneficiaries achieve a full and meaningful life in the community. The Peer Recovery Coach can assist with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery. The Peer Recovery Coach supports each beneficiary to fully participate in communities of their choosing in the environment most supportive of their recovery and that promotes housing of their choice to build recovery connections and supports. Utilizing a strength-based perspective and emphasizing assessment of recovery capital, services are designed to include prevention strategies and the integration of physical and behavioral health services to attain and maintain recovery

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				and prevent relapse. Beneficiaries utilizing Peer Recovery Coach services must freely choose the individual who is providing Peer Recovery Coach services. The Peer Recovery Coach shall receive regular supervision by a case manager, treatment practitioner, prevention staff or an experienced Certified Peer Recovery Coach who has over two continuous years in recovery and over two years in the direct provision of recovery coach services and supports. **Requirements** Individuals who work as a Peer Recovery Coach serving beneficiaries with substance use or co-occurring disorders must: • Be at least 18 years of age; • Have two continuous years in recovery from addition(s), with experience in navigating treatment services and/or prevention; • Share their recovery story as a tool in helping others; • Have experience receiving publicly-funded treatment and recovery services for addiction(s); • Be employed at least 10 hours per week by a licensed Substance Use Disorder Treatment Organization, a PIHP, a Community Mental Health Services Program, or another organization under contract to one or more of the forgoing organizations that provide substance abuse treatment and/or recovery support services; and • Attend and successfully complete the MDHHS Peer Recovery Coach training and certification.
			17.3.G.3. Youth Peer Support Services	Subsection was re-numbered as 17.3.G.**4.**
			17.3.G.4. Peer Mentoring Services	Subsection was re-numbered as 17.3.G.**5.**

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