MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 05-31

Distribution: All Providers

Issued: June 1, 2005

Subject: Updates to the Medicaid Provider Manual

Effective: July 1, 2005

Programs Affected: Medicaid, Children's Special Health Care Services, Adult Benefits Waiver, MOMS

The Michigan Department of Community Health (MDCH) has completed the July 2005 update of the online version of the Medicaid Provider Manual.

Three tables are attached to this bulletin detailing the changes made to the manual. The first table describes the technical changes being made, the location of the changes within the manual and, when appropriate, the reason for the change. These changes appear in yellow in the online version of the manual. The second table describes changes made to incorporate information from recently issued Medicaid Bulletins. These changes appear in pink in the online manual. The third table lists all Medicaid Bulletins not included in the January 2005 compact disc (CD) version of the manual that providers need to retain for reference.

If a change is made to a chapter of the online manual, a note will appear in the affected section/subsection title of that chapter's table of contents.

When utilizing the January 2005 CD version of the manual, refer to this bulletin in addition to the CD to assure you have all current policy information.

Manual Maintenance

If using the January 2005 CD version of the Medicaid Provider Manual, retain this bulletin and those referenced in this bulletin. If utilizing the online version of the manual at www.michigan.gov/mdch >>Providers>>Information for Medicaid Providers>>Medicaid Provider Manual, this bulletin and those referenced in this bulletin as being incorporated into the manual text may be discarded.

Questions

If you have questions about the manual, or problems locating information, you may contact Provider Inquiry at 1-800-292-2550 or providersupport@michigan.gov . If you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary.

Approved

Paul Reinhart, Director
Medical Services Administration

Michigan Department of Community Health

Medicaid Provider Manual
July 2005 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	6.2 Nonenrolled Michigan and Borderland Providers	The first sentence was changed to read: Medicaid pays nonenrolled Michigan and nonenrolled borderland providers for emergency services and for the first claim for nonemergency services **that were provided in compliance with Michigan Medicaid coverage policies**.	Clarification
General Information for Providers	Section 9 – Billing Beneficiaries	Reference to "spenddown" was changed to "Medicaid deductible".	Update
Beneficiary Eligibility	All	References to "spenddown" were changed to "Medicaid deductible". (Section 4 was renamed "Medicaid Deductible Beneficiaries".)	Update
Beneficiary Eligibility	2.1 Scope/Coverage Codes	The Scope Code table was updated as follows:	Update

Scope Code	Program	Qualifying Information
1	Medicaid	When used in conjunction with Coverage Codes E, F, P, Q, **T, U, or V**
2	Medicaid	When used in conjunction with Coverage Codes B, C, E, F, J, H, **T, V,** or 0 (zero)
3	Adult Benefits Waiver (ABW)	When used in conjunction with Coverage Codes G, M, or R
4	Refugees and Repatriates	When used in conjunction with Coverage Code F

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

TECHNICAL CHANGES*

<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td></td><td></td><td>The Coverage Code table was updated as follows:
<table>
<tr><th>Coverage Code</th><th>Qualifying Information</th></tr>
<tr><td>0 (zero)</td><td>No Medicaid eligibility/coverage (refer to Medicaid Deductible Beneficiaries Section of this chapter for more information)</td></tr>
<tr><td>B</td><td>Qualified Medicare Beneficiary (QMB) (pays Medicare Parts A & B premiums, coinsurance, and deductibles)</td></tr>
<tr><td>C</td><td>Specified Low Income Medicare Beneficiary (SLMB) (pays Medicare Part B premium)</td></tr>
<tr><td>D</td><td>Freedom to Work Beneficiary (full Medicaid coverage)</td></tr>
<tr><td>E</td><td>Emergency or urgent Medicaid coverage only</td></tr>
<tr><td>F</td><td>Full Medicaid coverage</td></tr>
<tr><td>G</td><td>Adult Benefits Waiver (full ABW coverage)</td></tr>
<tr><td>H</td><td>Additional Low Income Medicare Beneficiary (ALMB) (pays Medicare Part B premium)</td></tr>
<tr><td>J</td><td>Additional Low Income Medicare Beneficiary (ALMB) (pays part of Medicare Part B premium)</td></tr>
<tr><td>K</td><td>Freedom to Work Beneficiary (full Medicaid coverage)</td></tr>
<tr><td>M</td><td>PLUS CARE (Wayne County) (full PLUS CARE coverage)</td></tr>
<tr><td>P</td><td>Transitional Medical Assistance-Plus (TMA-Plus) (full Medicaid coverage)</td></tr>
<tr><td>Q</td><td>Medicare Qualified Disabled Working Individual (full Medicaid coverage)</td></tr>
<tr><td>R</td><td>Resident County Hospitalization only (administered by local DHS office)</td></tr>
<tr><td>T</td><td>Healthy Kids (full Medicaid coverage)</td></tr>
<tr><td>U</td><td>Transitional Medical Assistance-Plus (TMA-Plus) (emergency services only)</td></tr>
<tr><td>V</td><td>Healthy Kids (emergency services only)</td></tr>
<tr><td>Y</td><td>Family Planning Waiver (family planning services only)</td></tr>
</table></td><td>Update</td></tr>
</table>

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

Medicaid Provider Manual
July 2005 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Coordination of Benefits	2.6.E. Medicaid Liability	References to "spenddown" were changed to "Medicaid deductible".	Update
Billing & Reimbursement for Dental Providers	1.3 Additional Resource Material	The reference to "CDT-4 codes" was changed to "CDT codes".	Update
Billing & Reimbursement for Dental Providers	Section 2 – General Information/Prior Authorization	The first bullet was modified to read: ▪ X-rays must be sent along with the PA form. The last sentence in the subsection was deleted.	Update
Billing & Reimbursement for Dental Providers	2.1 Procedure Code Required Information	This subsection was deleted.	Incorrect information deleted.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Dental Providers	Section 5 – Special Billing Instructions	This section was reformatted and information added as follows: The two paragraphs of this section were moved under new subsection 5.1 Supernumerary Teeth. Subsection 5.2 Loss or Change in Eligibility was added with the following text: Providers can only bill for root canal therapy, complete and partial dentures, and laboratory-processed crowns if loss or change in eligibility occurs. Services must have been started prior to the loss of eligibility. • Bill with Not Otherwise Classified (NOC) procedure code D5899. • Include a copy of the lab bill for complete or partial dentures and laboratory-processed crowns. • Provide an explanation in the Remarks section of the claim. • For complete or partial dentures and laboratory-processed crowns, the date of service on the claim should be the date of the initial impression. • For root canal therapy, the date of service should be the first treatment appointment. Subsection 5.3 Incomplete Root Canal was added with the following text: • Providers must bill the Not Otherwise Classified (NOC) procedure code D3999. • Provide an explanation in the Remarks section of the claim. • Date of service should be the first treatment appointment.	Clarification
Billing & Reimbursement for Institutional Providers	5.6 Medicare	The following sentence was added at the end of the first paragraph: For additional information, refer to the Medicaid Liability subsection of the Coordination of Benefits Chapter.	Clarification

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	6.36 Therapies (Occupational, Physical and Speech-Language)	The following sentence was added at the end of the first paragraph: The appropriate modifier must always be used on the claim line to avoid a claim rejection when billing a dual-use code.	Clarification
Billing & Reimbursement for Institutional Providers	7.1 Revenue and CPT/HCPCS Codes	The definition for revenue code 0636 was changed to read: Drugs requiring detailed **coding**.	Correction
Billing & Reimbursement for Institutional Providers	8.11 Ancillary Physical and Occupational Therapy, Speech Pathology	The list of CPT codes/modifiers that can be billed with physical therapy revenue codes 0420, 0424, and 0429 was updated as follows: 95851, 95852, 97001, 97002GP, 97012, 97014, 97016, 97018GP, 97020, 97022GP, 97024, 97026, 97028, 97032GP, 97033, 97034, 97035GP, 97036, 97039, 97110GP, 97112GP, 97116GP, 97124GP, 97139GP, 97140, 97504GP, 97520, 97530GP, 97535GP, 97542GP, and 97799GP The list of CPT codes/modifiers that can be billed with occupational therapy revenue codes 0430, 0434, and 0439 was updated as follows: 92526, 95851, 95852, 97003, 97004, 97016, 97018GO, 97022GO, 97032GO, 97034, 97035GO, 97110GO, 97112GO, 97116GO, 97124GO, 97139GO, 97504GO, 97530GO, 97535GO, 97542GO, and 97799GO The following sentence was added at the end of the last paragraph: The appropriate modifier must always be used on the claim line to avoid a claim rejection when billing a dual-use code.	Update

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	8.14 Other Service Revenue Codes	The following information was added after the second and third bullets related to revenue codes 0250 and 0410 respectively: Interim reimbursement is based on a percentage of charge. Final reimbursement is calculated during the respective period's cost settlement and is based on that period's audited cost to charge ratio.	Clarification
Billing & Reimbursement for Institutional Providers	9.1 Intermittent Nursing Visits/Aide Visits/Therapies	The information at the end of the subsection regarding dual-use CPT codes to be used for OT and PT was deleted.	Deleted nonapplicable information.
Billing & Reimbursement for Professionals	3.1 CMS 1500 Claim Completion Instructions 6.2 Third Party Coverage	References to "spenddown" were changed to "Medicaid deductible".	Update
Billing & Reimbursement for Professionals	6.7.B. Days or Units	The code range included in the Gradient Compression Stockings/Surgical Stockings portion of the table was changed to L8100-L8150. The first sentence in the second paragraph in the Gradient Compression Stockings/Surgical Stockings portion of the table was changed to read: Surgical stockings and most gradient compression stockings are packaged by a pair and are billed with a quantity of "1" for each stocking.	Update
Adult Benefits Waiver	Section 2 – Coverage and Limitations	Information related to noncovered services in the Pharmacy portion of the table was changed to read: Noncovered: Injectable drugs used in clinics or physician offices.	Update

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Dental	Table of Contents	Procedure code D7999 – Not Otherwise Classified was added to the list in the text box at the top of the page. The paragraph at the bottom of the text box was deleted.	Update
Dental	Section 6 – Covered Services	References to the fourth edition of the Current Dental Terminology (CDT-4) were changed to Current Dental Terminology (CDT).	Update
Dental	6.3 Restorative Treatment	Some information in the subsection was reformatted and moved under this heading. The following information is now contained under 6.3: Restorative treatment is a benefit for beneficiaries under age 21. Amalgam or Resin-based Composite materials to restore carious lesions or fractured teeth are a covered benefit. Restorative treatment is limited to those services necessary to restore and maintain adequate dental health. No reimbursement is made for any surface more than once in two years. The replacement of restorations, **or any other restorative treatment (added 7/1/05)**, within two years of placement is the treating dentist's responsibility. Core build-up or post and core substructures are allowed for permanent teeth only.	Clarification
Dental	6.3.A. General Restorative Instructions	This subsection was renamed 6.3.A. Amalgam Restorations. The first and fourth paragraphs were moved to 6.3 Restorative Treatment. The following sentence was added at the end of the third paragraph that begins "For any restoration . . .": If pins are used, they are to be reported separately.	Update

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.3.B. Resin-Based Composite Restorations	This subsection was renamed 6.3.B. Resin-Based Composite Restorations – Direct.	Update
Dental	6.3.C. Crowns	The last paragraph in this subsection was moved to 6.3 Restorative Treatment.	Update
Dental	6.6.A. General Instructions	The first and fourth bullet were deleted. The second paragraph after the bullets was incorporated into bullets added at the end of this subsection. The following was added at the end of the subsection: Complete or partial dentures are not authorized when: • A previous denture has been provided within five years, whether or not the existing denture was obtained through Medicaid. • An adjustment, reline, repair, or duplication will make it serviceable. • Replacement of a complete or partial denture that has been lost or broken beyond repair is not a benefit within five years, whether or not the existing denture was obtained through Medicaid.	Update
Dental	6.6.B. Complete Dentures	Information related to when a denture is not authorized was moved to 6.6.A.	Update
Dental	6.6.C. Immediate Dentures	This subsection was renamed 6.6.C. Immediate Complete Denture. The first sentence of the subsection was changed to read: An immediate **complete** denture is a benefit only when the immediate extractions involve only the anterior teeth, whether Maxillary or mandibular.	Clarification
Dental	6.6.E. Interim Dentures	This subsection was renamed 6.6.E. Interim Complete and Partial Dentures. The second sentence was moved to the beginning of the paragraph.	Clarification

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.6.G. Repairs	The following sentence was added to the end of the first paragraph: Repairs for interim partial dentures are not covered.	Clarification
Dental	6.7.A. Extractions	The third paragraph was changed to read: Surgical extractions are not a covered benefit in cases of multiple extractions in the same quadrant **for preparation of complete dentures.**	Clarification
Hospice	6.3.G. Spenddown	The name of the subsection was changed to "Medicaid Deductible" and references to "spenddown" within the subsection were changed to "Medicaid deductible".	Update
Hospice	6.3.H. Room & Board to Nursing Facilities	The following bullet was added: **Hospice Revocation or Decertification.** If a Medicaid hospice beneficiary, who resides in a NF, revokes his hospice services or is deemed no longer certifiable for the Medicaid hospice benefit, the hospice may bill for services on the day of revocation/ decertification as well as the hospice/NF room and board, as long as the beneficiary is in the facility at the midnight census.	Clarification
Hospital	5.7 Inpatient Hospital Post-Payment Reviews	The third sentence in the first paragraph after the table was changed to read: The hospital is provided a list of beneficiaries (including beneficiary name, date of birth, and date(s) of service) to be audited **30 calendar** days prior to the ACRC visit.	Update
Hospital	5.13 Outpatient Hospital Post-Payment Reviews	The third sentence in the second paragraph was changed to read: The hospital is provided a list of beneficiaries (including beneficiary name, date of birth, and date(s) of service) to be audited **30 calendar** days prior to the ACRC visit.	Update
Hospital Reimbursement Appendix	7.6.A. Privately-Owned or Operated Inpatient Hospital Pool	This subsection was renumbered to 7.6.A.1. The term "privately owned" was added to the text when describing the DRG reimbursed hospitals and distinct part rehabilitation units.	Update/Clarification

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	7.6.B. Nonstate Government-Owned or Operated Inpatient Hospital Pool	This subsection was renumbered to 7.6.A.3. The term "nonstate government-owned" was added to the text when describing the DRG reimbursed hospitals and distinct part rehabilitation units.	Update/Clarification
Hospital Reimbursement Appendix	7.6.C. Privately-Owned or Operated Outpatient Hospital Pool	This subsection was renumbered to 7.6.A.2. The term "privately owned" was added to the text when describing the DRG reimbursed hospitals and distinct part rehabilitation units. The second paragraph was changed to read: Hospitals with Medicaid outpatient FFS payments share proportionately in this pool based on **each hospital's** total Medicaid FFS outpatient payments	Update/Clarification
Hospital Reimbursement Appendix	7.6.D. Nonstate Government-Owned or Operated Outpatient Hospital Pool	This subsection was renumbered to 7.6.A.4. The term "nonstate government-owned" was added to the text when describing the DRG reimbursed hospitals and distinct part rehabilitation units.	Update/Clarification
Laboratory	2.5 Component Billing	The second sentence in the third paragraph was changed to read: These are limited to certain services as noted on the **Clinical Laboratory Database** located on the MDCH website.	Correction
Medical Supplier	1.10 Noncovered Services	The 13th bullet was modified to read: Items for a beneficiary who is noncompliant with a physician's plan of care (or) items ordered for the purpose of solving problems related to noncompliance (e.g. insulin pump).	Clarification

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Medical Supplier	2.47 Wheelchairs, Pediatric Mobility Items and Seating Systems	The following sentence was added at the end of the first paragraph under Wheelchair Accessory in the Standards of Coverage portion of the table: Specific wheelchair accessories requested solely to facilitate transport of a beneficiary within a vehicle are not covered. The following sentence was added at the end of the first paragraph under Repairs in the Payment Rules portion of the table: The repair of a second (older) manual or power wheelchair used as a backup chair is not covered. References to custom-fitted DME were removed from the second bullet under Beneficiaries residing in a nursing facility in the Payment Rules portion of the table.	Clarification
Mental Health/ Substance Abuse	1.1 MDCH Approval	The first two sentences of the second paragraph were deleted and replaced with: For the Specialty Services and Supports Program, Centers for Medicare and Medicaid Services gave Michigan permission to use Section 1915(b)(3) of the Social Security Act which allows a state to use Medicaid funds to provide services that are in addition to the state plan services. Those services are described in the Additional Mental Health Services (B3s) section of this chapter.	Clarification

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	1.1 MDCH Approval 1.4 Provider Registry 2.1 Mental Health and Developmental Disabilities Services 2.3.A. Day Program Sites 2.4 Staff Provider Qualifications Section 3 – Covered Services Section 15 – Habilitation/Supports Waiver for Persons with Developmental Disabilities	References to "alternative" services were changed to "additional/B3" services.	Update
Mental Health/ Substance Abuse	1.7 Definition of Terms	The terms "Allowable Services" and "Alternatives" were deleted from the table.	Update
Mental Health/ Substance Abuse	2.2 Substance Abuse Services	The last sentence of the subsection was changed to read: All standard requirements of the Public Health Code, Article 6 – Substance Abuse, apply.	Clarification
Mental Health/ Substance Abuse	12.1 Covered Services	The second sentence of the first paragraph in the Intensive Outpatient (IOP) Treatment portion of the table was changed to read: Treatment consists of regularly scheduled treatment, usually group therapy, within a structured program, for at least three days and at least nine hours per week.	Update

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facilities (Coverages)	4.1.A. Verification of Medicaid Eligibility	The following information from 4.1.D.1. was added as the last paragraph in this subsection: Federal regulations require annual recertification that residents meet Medicaid financial eligibility requirements. The annual recertification process is performed by the Michigan Department of Human Services.	Clarification
Nursing Facilities (Coverages)	4.1.D.1. Michigan Medicaid Nursing Facility Level of Care Determination	The following was added to the list of bullets indicating when completion of the Nursing Facility LOC Determination is not required: • Cases where Medicaid reimbursement is requested for coinsurance days.	Clarification
Nursing Facilities (Coverages)	4.1.D.4. Annual Re-Certification	This subsection was renamed to 4.1.D.4. Ongoing Assessments and the text changed to read: The nursing facility must ensure that residents meet the Michigan Medicaid Nursing Facility LOC Determination criteria on an ongoing basis in order for services to be reimbursed by Medicaid. Quarterly and annual Minimum Data Set (MDS) assessments and progress notes must demonstrate that the resident has met the criteria on an ongoing basis.	Update
Nursing Facilities (Coverages)	4.1.D.6. Adverse Action Notice	The following was added at the end of the third paragraph: Both a facility representative and an MDCH LTC Services representative must be present at the hearing.	Update
Pharmacy	3.2 Enrollment	The information after the second sentence was changed to read: The Pharmacy Provider Enrollment and Trading Partner Agreement (MSA-1626) is available online at the PBM's website. (Refer to the Directory Appendix for website information.)	Update

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	13.4.B. Maximum Allowable Cost	The following sentence was inserted after the third sentence in this subsection: A monthly online MAC list is also available on the contractor's website.	Update
Pharmacy	13.10.B. COB Edit Exceptions	The first and last bullets in this subsection were deleted.	Update
Pharmacy	15.2 Unit Dose Policy	The information after the first sentence in the third paragraph was changed to read: The Unit Dose Pharmacy Agreement (MSA-0590) is available on the PBM's website. (Refer to the Directory Appendix for website information.)	Update
Pharmacy	16 – Public Health Service and Disproportionate Share Hospitals	The second sentence of the first paragraph was deleted and replaced with: A list of participating entities is located on the Bureau of Primary Health Care - Health Resources and Services Administration (HRSA) website. (Refer to the Directory Appendix for website information.)	Update
Practitioner	4.12 Immunizations (Vaccines and Toxins)	The following was inserted after the first sentence: An immunization administered for travel to a foreign country is not a Medicaid-covered benefit.	Clarification
Practitioner	4.20 Vision Services	The text of this subsection was deleted and the following sentence inserted: Refer to the Vision chapter of this manual for specific coverages.	Consistency
Practitioner	4.21 Orthoptic Services	The text of this subsection was deleted and the following information inserted: Strabismus surgeries are covered for beneficiaries of any age and do not require PA. Providers are reminded that these surgeries must be medically necessary and not performed solely for cosmetic purposes. Refer to the Vision chapter of this manual for other specific orthoptic coverages.	Inadvertently omitted. Issued as part of MSA 04-24 effective 1/1/05.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	Section 6 – Evaluation and Management Services	The following was added as a fourth paragraph: Do not report the modifier for unusual procedural services with E/M services in order to request individual consideration. This does not follow CPT coding guidelines and causes longer delays in processing the claims for payment.	Clarification
Practitioner	6.6 Nursing Facility Services (new subsection)	A new subsection, 6.6 Nursing Facility Services, was added with the following text: Visits necessary to perform Medicare and Medicaid required assessments are covered under the appropriate E/M services involving comprehensive resident assessments. Visits required to monitor and evaluate residents at the frequencies detailed in the coverage portion of the Nursing Facility chapter of this manual are also covered under the appropriate E/M service for subsequent nursing facility care. Additional visits for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, are only covered when documentation of the medical necessity for the visit is included on, or attached to, the claim. Documentation must include diagnoses describing the acute illness or injury; or remarks documenting the necessity for the additional visit recorded on the claim; or documentation such as notes from the visit supporting the above criteria attached to the claim. Additional visits which repeatedly reflect the same chronic diagnoses and additional visits for the purpose of routine monitoring are not covered. Refer to the Coverages portion of the Nursing Facility chapter of this manual for timeframes and additional details for required nursing facility visits.	Clarification
Program of All-Inclusive Care for the Elderly (PACE)	3.2 Completion of the Medicaid Nursing Facility LOC Determination	The following was added after the sixth paragraph: PACE organizations will not be reimbursed for participants who do not demonstrate eligibility through the electronic web-based tool. In addition, providers must submit participant information via the web no later than 14 calendar days following the start of service.	Clarification

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Program of All-Inclusive Care for the Elderly (PACE)	3.11.B. Functional/ Medical Eligibility	The word "applicant" in the second sentence was changed to "beneficiary".	Correction
Program of All-Inclusive Care for the Elderly (PACE)	3.12 Provider Appeals	The word "participant" in the first sentence was changed to "beneficiary".	Correction
Tribal Health Centers	All	References to "Alaskan Native" were changed to "Alaska Native".	Correction
Tribal Health Centers	6.2 MHP Enrollees	The word "counted" was changed to "recognized".	Clarification
Tribal Health Centers	6.3 Services Bundled in the Encounter	The word "rate" was removed from the end of the first sentence.	Correction
Tribal Health Centers	7.4 Co-Payments	The first sentence was changed to read: Co-payments that are required from Medicaid beneficiaries for some Medicaid-covered services are waived for American Indians and Alaska Natives.	Correction
Vision	3.1 Diagnostic Services	The diagnosis code range at the end of the first bullet in the Eye Examinations portion of the table was changed to 367-367.9.	Update
Directory Appendix	Pharmacy Resources	The following information was added: Topic: List of Participating Entities in 340B Program Website: http://bphc.hrsa.gov/opa/howto.htm	Update

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Provider Resources	The phone number for the MDCH Diaper & Incontinence Supply Contract (J&B Medical) was changed to: 800-737-0045	Update
Forms Appendix		Form substitution: Medicaid Ventilator Dependent Care Authorization (MSA-1635)	Revision to form
Glossary Appendix	Medicaid Deductible	The new term "Medicaid Deductible" was added with the following definition: Beneficiary must incur medical expenses each month equal to, or in excess of, an amount determined by the local DHS worker to qualify for Medicaid. Previously referred to as Medicaid Spenddown.	Update
Glossary Appendix	Spenddown	The definition for this term was deleted and replaced with: See "Medicaid Deductible".	Update

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

Michigan Department of Community Health

Medicaid Provider Manual
July 2005 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 05-29	6/1/05	Local Health Department	2.3 Administrative Services Section 3 – Medicaid Outreach Activities (New Section, Subsequent Sections Renumbered)	Local Health Departments providing approved Medicaid outreach activities may receive administrative match reimbursement through their Comprehensive Planning, Budgeting and Contracting (CPBC) Grant Agreement with MDCH.
MSA 05-26	5/15/05	School-Based Services Administrative Outreach Program	4.2 Time Study Participants	Eliminates three job categories from the list of allowable time study participants: Interpreter, Nurse Practitioner, and Bilingual Specialist/Translator.
MSA 05-24	5/1/05	Pharmacy	13.10.B. COB Edit Exceptions	Eliminates option to override pharmacy edits when other insurance carrier only has mail order pharmacy coverage.
MSA 05-23	4/1/05	Children's Special Health Care Services	5.4 Payment Agreement	The third paragraph containing information related to refunds for the difference between the MDCH expenditures and the amount contributed by the family was deleted.
			11.2 Out-of-State Travel	The statement indicating out-of-state travel assistance reimbursement is included as a state paid benefit in the payment agreement reconciliation process was deleted.
MSA 05-22	4/1/05	Hearing Aid Dealers	2.6.D. Payment Rules	The percent over acquisition cost was reduced to 9.6 percent.
			2.7.C. Payment Rules	The percent over acquisition cost was reduced to 9.6 percent.
			2.9.D. Payment Rules	The payment over actual costs was reduced to no more than $19.20.
			2.10.D. Payment Rules	The payment over acquisition cost was reduced to $19.20.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 05-19	4/1/05	Nursing Facility (Coverages)	11.3.B. Authorization for VDCU Placement	Inclusion of prior authorization number is required on claims for VDCU services.
MSA 05-17	3/1/05	Hospital Reimbursement Appendix	2.6 Episode File 2.7.C. Budget Neutrality Factor (new subsection) 2.7.D. Summary of DRG Price Calculations (was 2.7.C.) 2.8.A. High Day Outliers 2.8.D. Cost Outliers 2.9.A. Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units 3.2 Subacute Ventilator-Dependent Care 4.1 Medicaid Health Plan Payments to Out of Network Hospitals	Appendix updated to reflect current DRG and per diem policy transmitted in this bulletin.
MSA 05-13	3/15/05	Hospital Reimbursement Appendix	7.6 Medicaid Access to Care Initiative	Subsection was reformatted and expanded to include current MACI policy detailed in the bulletin. A chart detailing the MACI pools is available on the MDCH website at www.michigan.gov/mdch >>Providers>>Information for Medicaid Providers>>Provider Specific Information.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 05-02	1/1/05	Coordination of Benefits	Section 4 – Crossover Claims (new section)	A new section was added regarding crossover claims for Medicare Part B services.
All Provider 04-05	6/1/04	Billing & Reimbursement for Professionals	6.2 Third Party Coverage	Statement was added to the Medicare portion of the table referring billers to the Coordination of Benefits Chapter for crossover claim information.

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

Michigan Department of Community Health

Supplemental Bulletin List

The following is a list of Medicaid policy bulletins that supplement the *January 2005* electronic Medicaid Provider Manual. The list will be updated as additional policy bulletins are issued. The updated list will be posted on the MDCH website along with the Medicaid Provider Manual.

Providers affected by a bulletin should retain it until it is incorporated into the quarterly update of the online version of the manual unless instructed otherwise. Providers utilizing the CD version of the manual should retain bulletins until the next CD version is issued.

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
6/1/05	MSA 05-29	Local Health Department Medicaid Outreach Activities	Local Health Departments	7/1/05 Information added as new section in Local Health Department Chapter.
6/1/05	MSA 05-27	Implementation of 835 Remittance Advice and Electronic Funds Transfer for Pharmacies	Pharmacies	
5/15/05	MSA 05-26	Elimination of Three Job Categories From the List of Allowable Time Study Participants for School Based Services Administrative Outreach Activities	Intermediate School Districts/Detroit Public Schools	7/1/05 Changes made to the SBS Administrative Outreach Program Chapter.
5/05	MSA 05-25	Sanctioned Provider Monthly Update	All Providers	
5/1/05	MSA 05-24	Coordination of Mail Order Pharmacy Benefit	Pharmacies	7/1/05 Changes made to the Pharmacy Chapter.
4/1/05	MSA 05-23	Changes in CSHCS Payment Agreement Refund	Local Health Departments	7/1/05 Information added to the Children's Special Health Care Services Chapter.

Michigan Department of Community Health

Supplemental Bulletin List

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
4/1/05	MSA 05-22	FY 05 Fee Reductions (EO)	All Providers	Information regarding current fees/rates is available at www.michigan.gov/mdch >>Providers>>Information for Medicaid Providers >>Provider Specific Information
4/1/05	MSA 05-21	MI Choice Program Nursing Facility Transition Services and Waiting List Policy	MI Choice Waiver Program, Nursing Facilities	No change required in Nursing Facility Chapter. NFs may discard this bulletin after review.
4/1/05	MSA 05-20	Sanctioned Providers	All Providers	The list of sanctioned providers is available on the MDCH website at www.michigan.gov/mdch >>Providers>>Information for Medicaid Providers >>List of Sanctioned Providers. Providers without access to the internet should retain this bulletin.
4/1/05	MSA 05-19	Prior Authorization Number for Ventilator Dependent Care Unit (VDCU) Services	Hospital, Hospice, Medicaid Health Plans, Nursing Facility	7/1/05 Information added to the Nursing Facility Chapter. No changes necessary in other chapters.
3/1/05	MSA 05-18	April 2005 Medicaid Provider Manual Updates	All Providers	4/1/05 Information incorporated into appropriate chapters of the online manual.
3/1/05	MSA 05-17	Rebasing DRG Rates, DRG Groups Update, Per Diem Update	Hospitals, Medicaid Health Plans	7/1/05 Information added to the Hospital Reimbursement Appendix.

Michigan Department of Community Health

Supplemental Bulletin List

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
3/1/05	MSA 05-15	Place of Service	Maternal/Infant Support Services	4/1/05 Information added to Maternal/Infant Support Chapter, Section 2.10.
3/1/05	MSA 05-14	Revised Nursing Facility Coverages & Limitations and Reimbursement Chapters	Nursing Facilities	4/1/05 New Nursing Facility Chapter added to manual.
3/15/05	MSA 05-13	Update to Medicaid Access to Care Initiative (MACI)	Hospitals, Medicaid Health Plans	7/1/05 Information added to the Hospital Reimbursement Appendix.
3/1/05	MSA 05-12	New Coverage Criteria for Pull-On Briefs and Home Infusion Anti-Emetic Drugs; Clarification of Coverage Criteria for Glucose Monitoring Equipment/Supplies, High Frequency Chest Wall Oscillation (HFCWO) Device, and Pressure Gradient Garments/Surgical Stockings; and Clarification of Payment Rules for a Pulse Oximeter	Medical Suppliers	4/1/05 Information added to Medical Supplier Chapter, Section 2.
2/1/05	MSA 05-10	School-Based Services Administrative Outreach Claiming Methodology Changes	Intermediate School Districts/Detroit Public Schools	4/1/05 Information added to SBS Administrative Outreach Program Chapter, subsection 6.2.
3/1/05	MSA 05-09	Clarification to Nursing Facility Level of Care Determination Policy (MSA 04-15 and MSA 04-17)	Nursing Facilities, MI Choice, PACE, Hospitals, Hospice, Medicaid Health Plans, Mental Health/Substance Abuse	4/1/05 Information added to Hospital, Nursing Facility (new), and PACE (new) chapters.
2/1/05	MSA 05-07	Program of All-Inclusive Care for the Elderly (PACE)	All Providers	4/1/05 New PACE Chapter added to the manual.
2/1/05	MSA 05-06	Adult Benefits Waiver Changes	All Providers	4/1/05 Information added to the Adult Benefits Waiver Chapter.

Michigan Department of Community Health

Supplemental Bulletin List

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
1/1/05	MSA 05-05	Payments to Hospice Providers for Nursing Facility QAS	Hospice, Nursing Facilities	4/1/05 Information added to Hospice Chapter, subsection 6.3.H.
1/1/05	MSA 05-04	Optional Mail Order Pharmacy Benefit	Pharmacy, Practitioners, Mental Health/Substance Abuse, FQHCs, Local Health Departments, Rural Health Clinics, Tribal Health Centers	4/1/05 Information added to Pharmacy Chapter, subsections 5.1 and 13.6.
1/1/05	MSA 05-03	Expansion of Covered Services for Certified Nurse Midwives	Certified Nurse Midwives, Practitioner	4/1/05 Information added to the Practitioner Chapter, subsections 24.3 and 24.4.
1/1/05	MSA 05-02	Medicare Crossover Claims with AdminaStar	Practitioners, FQHCs, Medical Suppliers, Vision, Rural Health Clinics, Local Health Departments	7/1/05 Information added to the Coordination of Benefits Chapter, Section 4 (new).
10/1/04	Nursing Facilities 04-07	Nursing Facility Certification, Survey and Enforcement	Nursing Facilities	4/1/05 New Nursing Facility Chapter added to manual.
6/1/04	All Provider 04-05	New editing, explanation code crosswalk, and crossover claims.	All Providers	7/1/05 Information related to crossover claims incorporated into the Coordination of Benefits Chapter, Section 4 (new). Edit codes and explanation code crosswalk are available on the MDCH website at www.michigan.gov/mdch >> Providers>>Information for Medicaid Providers>>Provider Specific Information.