MSA MEDICAL SERVICES ADMINISTRATION

# Bulletin

**Michigan Department of Community Health**

**Bulletin Number:** MSA 13-05

**Distribution:** All Providers

**Issued:** March 1, 2013

**Subject:** Updates to the Medicaid Provider Manual; Coding Updates; ICD-10 Project Update; ListServ Communications

**Effective:** April 1, 2013

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

## Updates to the Medicaid Provider Manual

The Michigan Department of Community Health (MDCH) has completed the April 2013 update of the online version of the Medicaid Provider Manual. Attachments to this bulletin describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change.

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.

## Coding Updates

- 81266 – Prior Authorization (PA) is **not** required for this code (correction to bulletin MSA 12-70)
- J0890 – covered for Physicians, Nurse Practitioners, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers effective January 1, 2013
- L4631 – covered for Orthotists and Prosthetists effective January 1, 2013; requires PA

Providers should refer to the databases maintained on the MDCH website for additional code information.

## ICD-10 Project Update

MDCH continues to transition its policies, procedures and information systems to support the ICD-10 code sets on all Health Insurance Portability & Accountability Act (HIPAA) transactions by the federally mandated compliance date of October 1, 2014. As part of this process, testing activities are planned to begin by October of 2013. MDCH will present Medicaid providers and trading partners with an opportunity to test their ability to communicate with MDCH using ICD-10 coded transactions. This testing will be designed to help providers ensure that their remediation efforts to prepare for the implementation of ICD-10 coding have resulted in the creation of transactions that can be successfully processed.

In the meantime, providers are encouraged to communicate with their software vendors, billing agents and/or service bureaus to ensure systems and procedures will support the use of ICD-10 code sets on all HIPAA transactions so that payers, such as MDCH, and trading partners may continue to process these transactions without interruption after October 1, 2014.

Any questions regarding ICD-10 implementation should be directed by e-mail to MDCH-ICD-10@michigan.gov. Providers should continue to check the MDCH website at www.michigan.gov/5010icd10 frequently for ICD-10 updates, including additional details regarding testing opportunities and procedures in upcoming months.

**ListServ Communications**

The Medical Services Administration (MSA) offers the option for anyone to receive MDCH policy, billing, and various Medicaid-related information through an e-mail listserv. Announcements are periodically sent through this listserv to those subscribed to it. Anyone wishing to subscribe may do so at any time. Subscription instructions are posted on the MDCH website at www.michigan.gov/medicaidproviders. Click "Listserv Instructions" under Hot Topics.

**Manual Maintenance**

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

**Questions**

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

**Approved**

Stephen Fitton, Director
Medical Services Administration

Michigan Department of Community Health

# Medicaid Provider Manual
# April 2013 Updates

## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| General Information for Providers | 15.7 Clinical Records | In the table after the 5th paragraph, the following documentation requirements were removed from MI Choice:<br>• Presenting Symptom, Condition<br>• Orders for Tests & Test Results<br>• Identification of Specimen, Type & Source<br>• Name, Strength, Dosage, Quantity & Route of Drug, and Time Administered | These requirements are obsolete. |
| Beneficiary Eligibility | 9.4 CHAMPS Eligibility Inquiry | The 1st bullet point was revised to read:<br>• Benefit Plan ID of MA-MC, CSHCS-MC or MME-MC | Addition of MME-MC |
| Billing & Reimbursement for Dental Providers | 3.2 Paper Claims | In the 4th paragraph, the 1st sentence was revised to read:<br>Questions and/or problems with the compatibility of equipment with MDCH scanners should be directed to MDCH Provider Inquiry. | Update |
| Billing & Reimbursement for Institutional Providers | 2.2 Paper Claims | In the 4th paragraph, the 1st sentence was revised to read:<br>Questions and/or problems with the compatibility of equipment with MDCH scanners should be directed to MDCH Provider Inquiry. | Update |
| Billing & Reimbursement for Institutional Providers | 8.2.C. Offset to Patient-Pay Amount for Noncovered Services | The following text was inserted as the 1st paragraph:<br>**NOTE:** This section does not pertain to Pre-Eligibility Medical Expenses (PEME). PEME must not be reported on the claim. (Refer to the Directory Appendix for PEME contact information.) | Clarification |

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| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Billing & Reimbursement for Institutional Providers | 11.3 Application of the Patient-Pay Amount | The following was added as the 1st paragraph:<br>CHAMPS handles the Patient-Pay Amount (PPA) in the following manner: When a beneficiary has a monthly PPA and a level of care (LOC) for nursing facility (02) and hospice (16) on file, the PPA will be deducted from the first claim received in CHAMPS. This will occur regardless of whether the PPA is located on the eligibility segment for LOC 02 or LOC 16, and the higher PPA amount will be deducted. If the PPA is greater than the amount of the first submitted claim, the difference will be applied to subsequent claims until the total PPA for that month is met. The PPA must be exhausted each month before any Medicaid payment will be made. The nursing facility and hospice must bill in sequence according to the level of care the beneficiary was at on the first of the month. This will prevent the PPA from being deducted from the wrong claim. | |
| Billing & Reimbursement for Institutional Providers | 11.4 Offset to Patient Pay Amount for Noncovered Services | The following text was inserted as the 1st paragraph:<br>**NOTE:** This section does not pertain to Pre-Eligibility Medical Expenses (PEME). PEME must not be reported on the claim. (Refer to the Directory Appendix for PEME contact information.) | Clarification |
| Billing & Reimbursement for Professionals | 2.2 Paper Claims | In the 4th paragraph, the 1st sentence was revised to read:<br>Questions and/or problems with the compatibility of equipment with MDCH scanners should be directed to MDCH Provider Inquiry. | Update |
| Billing & Reimbursement for Professionals | 6.19 Radiology Services | Addition of:<br>**Referring/Ordering Provider** — Diagnostic radiology services that are a result of a physician's order or referral require the submission of the referring/ordering Medicaid provider name and NPI in items 17 and 17b. | Clarification of billing requirements for radiology services |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Ambulance | 1.3 Ambulance Services | The 2nd paragraph was removed and information was re-located to subsection 2.9 Nonemergency.<br><br>The 3rd paragraph was revised to read:<br><br>The beneficiary's attending physician must order all nonemergency, medically necessary ambulance transportation. The ambulance provider must retain all documentation supporting the nature of the service in the beneficiary's file regardless of the level of service provided. (Refer to the Emergency and Nonemergency subsections of this chapter for additional information.) | |
| | 2.9 Nonemergency | The 1st paragraph was revised to read:<br><br>A claim may be made to MDCH for a medically necessary nonemergency transport only when:<br><br>• the transport is ordered by the beneficiary's attending physician;<br>• the ambulance provider obtains a written order (e.g., physician certification statement) from the beneficiary's attending physician certifying the medical necessity of the transport; and,<br>• the transport is provided in a licensed BLS or ALS vehicle.<br><br>Ambulance providers must retain appropriate documentation of the medical necessity of the transport in their files. A copy of the physician's order for nonemergency ambulance transport in the patient's medical record is acceptable documentation.<br><br>A physician may order nonemergency ambulance transports for a beneficiary with a chronic condition to a planned treatment that covers up to one month of treatment. The written order must contain, at a minimum, the following information:<br><br>• beneficiary's name and Medicaid identification (ID) number;<br>• attending physician's NPI number and attending physician or provider signature;<br>• type of transport necessary; | |

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<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td></td><td></td><td>• explanation of the medical necessity for ambulance transport (i.e., why other means of transport could not be used);<br>• frequency of needed transport;<br>• origin;<br>• destination; and<br>• diagnosis.</td><td></td></tr>
<tr><td rowspan="2">Dental</td><td rowspan="2">6.2.B. Topical Application of Fluoride</td><td>The 1st and 2nd paragraphs were revised to read:<br><table><tr><td>Non-Varnish</td><td>Topical application of fluoride is a benefit for beneficiaries under age 16. It is covered only once every six months. The fluoride must be approved by the ADA Council on Dental Therapeutics and administered using tray application.</td></tr><tr><td>Varnish</td><td>Topical application of fluoride varnish is a benefit for beneficiaries under age 16. Frequency and parameters vary based on the age of the beneficiary as noted below:<br>• Ages 0-2: Four times per 12 months as a therapeutic application for moderate to high caries risk patients.<br>• Ages 3-15: One time per six months.</td></tr></table></td><td>Clarification</td></tr>
<tr><td>In the 3rd paragraph, the 5th (last) bullet point was revised to read:<br>Prescription fluoride supplements prescribed by the dentist (may be covered as a pharmacy benefit for beneficiaries under the age of 10).</td><td>Clarification</td></tr>
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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Dental | 6.3 Restorative Treatment | The 1st and 2nd paragraphs were revised to read:<br>Restorative treatment, using Amalgam or Direct Resin-Based Composite materials to restore carious lesions or fractured teeth, is a covered benefit for all beneficiaries. Limited indirect restorations (crowns) are covered for beneficiaries under age 21. Restorative treatment is limited to those services necessary to restore and maintain adequate dental health.<br>Replacement or repair of a restoration is the provider's responsibility for the first two years following placement of all restorations. Refer to the MDCH Dental Database on the MDCH website for specific frequency limits. (Refer to the Directory Appendix for website information.) | Clarification |
| Dental | 6.3.C. Crowns | The subsection title was revised to read: "Indirect Restorations."<br>The 1st paragraph was revised to read:<br>Limited crown coverage for beneficiaries under age 21 includes:<br>**Provisional Crowns**<br>• Stainless steel crown – for primary teeth and permanent molars<br>• Stainless steel crown with resin window – for anterior primary teeth<br>**Crowns**<br>• Laboratory-processed resin crown and ¾ resin crowns (indirect) – for anterior permanent teeth only; prior authorization (PA) is required. | Clarification |
| Dental | 6.4.G. Apicoectomy | Subsection text was revised to read:<br>Apicoectomy is a surgical procedure to repair a root pathology, defect, fracture or removal of extruding instruments, materials or root fragments. It also includes the sealing of accessory canals. An apicoectomy should be done only after a tooth has had at least one root canal procedure and retreatment has not been successful or is not possible. | Clarification |

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|---|---|---|---|
| Hearing Aid Dealers | 2.6.A. Standards of Coverage | The 1st paragraph was revised to read:<br>Hearing aid supplies and accessories are considered a benefit, if necessary. A separate list of approved supplies, accessories, and maximums is available in addition to the MDCH Hearing Aid Dealers Database on the MDCH website. (Refer to the Directory Appendix for website information.)<br>The table following the paragraph was removed as information is available on the MDCH website. | Change being made to be consistent with the parts and accessories list for cochlear implants and auditory osseointegrated devices previously removed from hearing services policy. |
| Hospice | 7.3.C. Date of Discharge | In the 2nd paragraph, the last sentence was revised to read:<br>Room and board reimbursement for the day of discharge from the NF for any other reason is not covered. | |
| Hospice | 7.3.E. Patient-Pay Amount | The following was added as a 3rd paragraph:<br>CHAMPS handles the PPA in the following manner: When a beneficiary has a monthly PPA and a level of care (LOC) for nursing facility (02) and hospice (16) on file, the PPA will be deducted from the first claim received in CHAMPS. This will occur regardless of whether the PPA is located on the eligibility segment for LOC 02 or LOC 16, and the higher PPA amount will be deducted. If the PPA is greater than the amount of the first submitted claim, the difference will be applied to subsequent claims until the total PPA for that month is met. The PPA must be exhausted each month before any Medicaid payment will be made. The nursing facility and hospice must bill in sequence according to the level of care the beneficiary was at on the first of the month. This will prevent the PPA from being deducted from the wrong claim. | |

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|---|---|---|---|
| Hospital | 5.9.B. Complex Care | In the 3rd paragraph:<br>• the 1st bullet point was revised to read "Referrals must come from the nursing facility."<br>• the 3rd bullet point was removed.<br>The 4th paragraph was removed in its entirety.<br>The 5th paragraph was revised to read:<br>If it appears that a beneficiary, upon discharge, will require intensive nursing care, the hospital's discharge planning coordinator should initiate nursing facility contact as early in the beneficiary's hospital stay as possible to ensure a smooth transition to the nursing facility.<br>The 6th paragraph was removed in its entirety. | Section revised as hospitals no longer submit the MSA-1576. |
| Maternal Infant Health Program | 2.2 Infant Risk Identifier | In the 3rd paragraph, the following text was inserted after the 2nd sentence:<br>All visits beyond the original nine visits must have a written physician order. | Clarification |
| Medical Supplier | 1.10 Non-Covered Items | In the 1st paragraph, the following bullet point was removed:<br>• Thickeners for foods or liquids (e.g., Thick – it) | NOTE: Standards of coverage and prior authorization requirements remain the same. |
| Nursing Facility Coverages | 10.3 Ancillary Services | In the 1st paragraph, the 1st sentence was revised to read:<br>Ancillary services (i.e., services other than daily care services), excluding physician services, must be ordered and documented, ... | Clarifies that physician services are not considered an ancillary service. |
| Nursing Facility Coverages | 10.36.D.3. Process | In the 1st paragraph, the 1st and 2nd sentences were revised to read:<br>The MDCH consultant will make a determination and return to the provider a letter indicating approved, denied, insufficient data, no action, or approved as amended. If approved, the approval letter will contain a PA number with start and end dates. | Updated to read that a letter is returned to the provider rather than the MSA-115. |

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|---|---|---|---|
| Nursing Facility Coverages | 11.5 Complex Care | In the 3rd paragraph, the 1st bullet point was revised to read "Referrals must come from the nursing facility."<br><br>In the 4th paragraph, 1st bullet point, the following text was added after the 1st sentence:<br><br>NOTE: The only supplies or equipment that will be considered are those not included in the facility's per diem rate or not separately billable by a Medicaid-enrolled medical supplier.<br><br>In the 4th paragraph, the 2nd bullet point was revised to read:<br><br>• The beneficiary's medical background, including:<br>➢ current medical status;<br>➢ admitting history and physical;<br>➢ a copy of all consultations;<br>➢ most recent three-day physician progress notes;<br>➢ treatment/nursing care plan; and<br>➢ justification for any additional nursing hours and/or special equipment requested.<br><br>(This information should be included on the MSA-1576.)<br><br>In the 4th paragraph, the 3rd bullet point was revised to read:<br><br>• Recent (within the past 30 days) lab, x-ray, and diagnostic or therapeutic test results or reports.<br><br>In the 4th paragraph, the 4th bullet point was revised to read:<br><br>• A list of 10 nursing facilities (as documented by the hospital) within a 50-mile radius that have denied admission, including:<br>➢ Name, address, and telephone number of the nursing facility ... | Revised to indicate it may take 15 business days to process the MSA-1576 rather than three weeks; response may be in the form of a letter rather than through the MSA-1576.<br><br>Update of documentation requirements. |

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|---|---|---|---|
| | | In the 5th paragraph, the 1st sentence was revised to read:<br>It may take up to 15 business days for the MSA-1576 to be processed.<br>The 6th paragraph was revised to read:<br>MDCH will make a determination and return to the provider a letter indicating approved, denied, insufficient data, no action, or approved as amended. If approved, the approval letter will contain a PA number with start and end dates. To renew a request, the facility must submit another MSA-1576 at least 15 business days prior to the expiration/end date. | Revised to indicate it may take 15 business days to process the MSA-1576 rather than three weeks; response may be in the form of a letter rather than through the MSA-1576.<br>Update of documentation requirements. |
| Practitioner | 4.10 Foot Care, Routine | The subsection was re-named to read: "Foot Care."<br>Two additional subsections were created to separate information into specific subject matter. | Combination of related policy coverage topics. |
| Practitioner | 4.10.A. Routine Foot Care | New subsection text reads:<br>Medicaid covers these services when provided by a physician or podiatrist and when the beneficiary manifests signs and symptoms from a specific systemic disease of sufficient severity that care by a nonprofessional would be hazardous. The medical necessity for these services must be documented in the beneficiary's medical record, and the beneficiary must be receiving regular care from a physician for the systemic disease. | |
| Practitioner | 4.10.B. Mycotic Nails, Debridement | Re-numbering/re-locating of subject matter text. | Information was previously numbered 4.15. |
| Practitioner | 4.15 Mycotic Nails, Debridement | Information re-located to 4.10.B. Mycotic Nails, Debridement.<br>Following subsections were re-numbered. | |

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| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Practitioner | 23.3 Nursing Facility Services (new subsection) | New subsection text reads:<br>Podiatry services provided to a beneficiary in a nursing facility are considered an ancillary service and require the written order of the beneficiary's attending physician. All terms and conditions related to Medicaid covered and non-covered services, including PA and billing requirements, apply to services provided to beneficiaries in a nursing facility. | Clarification of NF policy as it relates to podiatry practitioners. |
| Private Duty Nursing | 1.3 Provision of Private Duty Nursing | In the 4th paragraph, the 1st sentence was revised to read:<br>If a beneficiary's services are performed exclusively by LPNs, the supervisory RN is responsible for completing a physical assessment for each beneficiary the LPN is caring for, and is required to participate in the development of the beneficiary's plan of care. | |
| Private Duty Nursing | 1.4 Prior Authorization | In the 4th paragraph, the 1st sentence was revised to read:<br>Following receipt and review of the MSA-0732 and the required documentation by the Program Review Division, a notice is sent to the PDN provider .... | Clarification |
| Private Duty Nursing | 2.4 Determining Intensity of Care and Maximum Amount of PDN | In the 5th (last) paragraph, 6th (last) bullet point, 2nd paragraph, the last sentence was revised to read:<br>The Medicaid PDN benefit cannot be used to replace the LSD's or ISD's responsibility for services (either during transportation to/from school or during participation in the school program) or when the child would typically be in school but for the parent's choice to home-school the child. | |
| Acronym Appendix | | Addition of:<br>PEME – Pre-Eligibility Medical Expenses | Update. |
| Directory Appendix | Claim Submission/ Payment | Information for "OCR Coordinator" was removed. | Obsolete information. |
| Directory Appendix | Nursing Facility Resources | Under "MDCH, LTC Services", "private room approvals" was removed from "Information Available/Purpose." | Update. |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Directory Appendix | Nursing Facility Resources | Under "Nursing Facility Forms & Instructions, Calculation Examples, Rate Relief Worksheet", "Medicaid State Plan" was removed from "Information Available/Purpose." | Update. |
| Directory Appendix | Nursing Facility Resources | Addition of:<br>Contact/Topic: Pre-Eligibility Medical Expenses (PEME)<br>Phone#/Fax #: Phone = 517-241-4302; Fax = 517-241-8556<br>Mailing/E-Mail Address:<br>MDCH Medical Services Administration<br>Attention: PEME<br>P.O. Box 30479<br>Lansing, MI 48909-9634<br>Martina2@michigan.gov<br>Information Available/Purpose: MDCH review of offsetting unpaid PEME. | |
| Directory Appendix | Pharmacy Resources | Under "Pharmacy Audits", the website was revised to read:<br>http://www.michiganmedicaidrxaudit.com | Update. |

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# Medicaid Provider Manual
# April 2013 Updates

## BULLETINS INCORPORATED*

| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
|---|---|---|---|---|
| MSA 12-71 | 1/15/2013 | Ambulance | 2.9 Nonemergency | The 3rd paragraph was revised to read:<br>If the ambulance provider is unable to obtain a signed physician certification statement from the beneficiary's attending physician, a signed certification statement must be obtained from the physician's assistant, nurse practitioner, clinical nurse specialist, registered nurse, or discharge planner who is knowledgeable about the beneficiary's condition and who is employed by the attending physician or facility to which the beneficiary was admitted. |
| | | Practitioner | 4.2 Ambulance Services | The 3rd paragraph was revised to read:<br>The physician must order all nonemergency, medically necessary ambulance transportation. Refer to the Ambulance Chapter for order requirements and additional information related to ambulance services.<br>The 4th and 5th paragraphs were deleted. |
| MSA 12-70 | 12/28/2012 | School Based Services | 2.5 Psychological, Counseling and Social Work Services | Under "Procedure Codes", 2nd paragraph, the following codes were removed: **90804, 90806, 90810 and 90812**.<br>Under "Procedure Codes", 2nd paragraph, the following information was added:<br>• **90832** – Psychotherapy, 30 minutes with patient and/or family member.<br>• **90834** – Psychotherapy, 45 minutes with patient and/or family member.<br>• **90785** – Interactive complexity (List separately in addition to the code for primary procedure). |

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## BULLETINS INCORPORATED*

| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
|---|---|---|---|---|
| MSA 12-64 | 12/28/2012 | Maternal Infant Health Program | 2.10 Transportation | Subsection text was re-written its entirety to read:<br><br>Transportation services are available to help MIHP-enrolled beneficiaries access their health care and pregnancy-related appointments. The MIHP provider should assess each MIHP beneficiary's needs, and this assessment should be documented in the beneficiary's chart. Transportation is provided by the MIHP only when no other means of transportation are available. Transportation is available through the MIHP, MHP, and the local Department of Human Services (DHS). MIHP providers should coordinate with local DHS offices which may have transportation resources available. The Care Coordination Agreement between the MIHP and the MHP should specify how best to provide for transportation needs. MHPs are responsible for transportation services to all medically-related services. MIHPs may provide transportation services to other pregnancy-related appointments such as WIC appointments, childbirth/parenting education classes (if not covered by the MHP) and mental health/substance abuse appointments. Transportation services are also available for a mother to visit her hospitalized infant.<br><br>For women and infants who are enrolled in fee-for-service (FFS) Medicaid, the MIHP may provide transportation services for medical/health care, mental health services, substance abuse treatment, WIC visits, and for most MIHP services, including childbirth/parenting education classes. For women and infants who are enrolled in a MHP, all medical/health care transportation services should be arranged by the MHP. The MIHP may arrange or provide transportation services for the remainder of the MIHP services.<br><br>Transportation is available for the infant and the primary caregiver to attend the infant's appointments when the infant is enrolled in the MIHP. Transportation services may be billed under the mother's Medicaid ID number for the pregnant woman and under the infant's Medicaid ID number for the infant. |

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| | | | | MDCH reimburses the MIHP provider an administrative fee equal to six percent of the cost of the transportation. When billing, the six percent fee should be calculated and included in the amount charged, not to exceed the maximum amount allowed. The MIHP provider must determine the most appropriate and cost effective method of transportation. MDCH reimburses transportation cost at the lesser of actual cost or the maximum/upper limit for:<br>• Bus<br>• Mileage (volunteer/relative/beneficiary/other)<br>• Taxi (If other methods of transportation are not available or appropriate, the MIHP provider may make arrangements with local cab companies to provide taxi service for MIHP beneficiaries. Since this is a more expensive service, MDCH reimburses a maximum of 20 trips per beneficiary through the MIHP.<br>The MIHP provider must maintain documentation of transportation for each beneficiary for each trip billed. The record must specify:<br>• The name and address of the beneficiary;<br>• The date of service (DOS);<br>• The trip's starting point and destination (address, city);<br>• The purpose of the trip;<br>• The number of tokens or miles required for the trip; and<br>• The amount that the beneficiary or transportation vendor was reimbursed.<br>The MIHP provider must ensure the beneficiary kept the appointment for which transportation tokens or funds were provided. Medicaid does not pay for transportation not provided. |

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| | | | | The MIHP provider may give transportation tokens or funds to the pregnant woman or to the caregiver of the infant. In situations where funds are provided, it is recommended that the pregnant woman or the caregiver sign a receipt and that the receipt be retained in the case records. The MIHP may also contract for transportation services. Transportation services should be billed for each date of service it was provided.<br><br>MDCH contracts with a transportation brokerage company to arrange and provide Non-Emergency Medical Transportation (NEMT) for beneficiaries residing in Wayne, Oakland and Macomb counties. Transportation may be provided when the beneficiary qualifies for service and has no other means of transportation. (Refer to the Directory Appendix for contractor contact information.)<br><br>Beneficiaries in the Nurse Family Partnership (NFP) (another MDCH program) do not need a risk identifier completed to receive transportation services. Transportation is the only MIHP service available to NFP beneficiaries. |
| | | Directory Appendix | Maternal Infant Health Program Resources<br><br>(new subsection) | Addition of the following information:<br><br>Contact/Topic: LogistiCare Solutions<br><br>Phone #/Fax #: (866) 569-1902<br><br>Information Available/Purpose: non-emergency medical transportation for qualifying beneficiaries in Wayne, Oakland, and Macomb counties |
| MSA 12-66 | 12/1/2012 | Practitioner Reimbursement Appendix | Section 3 – Primary Care Provider Rate Increase<br><br>(new section) | Section text reads:<br><br>For dates of service on and after January 1, 2013 and through December 31, 2014, MDCH will apply an increased payment rate to enrolled practitioners for primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The increase will apply to a specific set of services and procedures designated by the Centers for Medicare & Medicaid Services (CMS) as "primary care services." These payments are made as a directive of Section 1202 of the Affordable Care Act (ACA). |

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| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
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| | | | 3.1 Provider Eligibility<br>(new subsection) | Subsection text reads:<br>Physicians with specialty designations of family medicine, general internal medicine, and pediatric medicine qualify as primary care providers for purposes of increased payment. Services provided by all subspecialists related to these three designated specialty categories, recognized by the American Board of Medical Specialties, American Osteopathic Association, and the American Board of Physician Specialists, will qualify for the higher payment for primary care services.<br>Identification of Eligible Providers<br>Before enhanced payments are made, MDCH will verify that a physician meets the regulation's eligibility criteria which are identified as being either board certified in an eligible specialty or by conducting a thorough review of the physician's practice characteristics.<br>• Board Certification: A primary care physician (PCP) who has self-attested by designating their primary specialty in their Community Health Automated Medicaid Processing System (CHAMPS) enrollment file as one of the three eligible specialties and has provided applicable Board certification information will be validated by MDCH prior to any enhanced payment.<br>• Review of Practice Characteristics: For non-board-certified physicians, Medicaid will review an enrolled provider's billing history for CY 2012. At least 60 percent of the physician's codes paid by Medicaid for all of CY 2012 must be for the evaluation and management (E/M) codes and vaccine administration codes specified in this regulation. This review of practice characteristics will be done by MDCH 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. |
| | | | 3.2 Eligible Primary Care Services<br>(new subsection) | Subsection text reads:<br>CMS has identified that Healthcare Common Procedure Coding System (HCPCS) E/M codes 99201 through 99499 are subject to the rate increase. In addition, vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474 are also eligible for the higher payment. MDCH will not be providing coverage of previously non-covered codes within this range as a result of this initiative. |

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| | | | 3.3 Enhanced Rates for Primary Care<br>(new subsection) | Subsection text reads:<br>For providers identified as eligible for the rate increase, payment will be made on the qualified procedure codes at the Medicare Physician Fee Schedule (MPFS) rates for CYs 2013 and 2014 or, if higher, the rate that will be applicable using the CY 2009 Medicare conversion factor. MDCH will apply the Medicare site of service (Facility vs. Non-Facility) differential and the Medicare geographic adjustment. MDCH will also apply Medicare's two-tiered rates for locality 01 and locality 99 as defined by Medicare. Payment for the locality differential for services paid under this incentive will be determined by using the validated 9-digit ZIP code on the claim for where the service was performed. MDCH will provide a separate fee schedule database for the two-year rate increase which will be located on the MDCH website. (Refer to the Directory Appendix for website information.) |
| MSA 12-65 | 12/1/2012 | Billing & Reimbursement for Dental Providers | 1.2 Predictive Modeling<br>(new subsection; following subsection re-numbered) | Subsection text reads:<br>Predictive modeling, a pre-payment claims process in CHAMPS, uses advanced screening technology to identify Medicaid claims with billing irregularities. Claims flagged by the predictive modeling process will undergo a detailed analysis to determine the next step(s) to be taken. This may include a review of medical records and/or past claims. Providers must submit the requested records within 30 days of the date on the request for documents letter to avoid denials for lack of documentation.<br>Requested records must be submitted through Documentation EZ Link using the Predictive Modeling Claim Documentation form (MSA-0004-EZ) or as an EZ Link attachment with code word "MDCHPM" and the Transaction Control Number (TCN) in the message subject line. (Refer to the Forms Appendix for a copy of MSA-0004-EZ. Refer to the Directory Appendix for Documentation EZ Link website information.) |

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| | | Billing & Reimbursement for Institutional Providers | 1.2 Predictive Modeling<br>(new subsection; following subsection re-numbered) | Subsection text reads:<br>Predictive modeling, a pre-payment claims process in CHAMPS, uses advanced screening technology to identify Medicaid claims with billing irregularities. Claims flagged by the predictive modeling process will undergo a detailed analysis to determine the next step(s) to be taken. This may include a review of medical records and/or past claims. Providers must submit the requested records within 30 days of the date on the request for documents letter to avoid denials for lack of documentation.<br>Requested records must be submitted through Documentation EZ Link using the Predictive Modeling Claim Documentation form (MSA-0004-EZ) or as an EZ Link attachment with code word "MDCHPM" and the Transaction Control Number (TCN) in the message subject line. (Refer to the Forms Appendix for a copy of MSA-0004-EZ. Refer to the Directory Appendix for Documentation EZ Link website information.) |
| | | Billing & Reimbursement for Professionals | 1.2 Predictive Modeling<br>(new subsection; following subsection re-numbered) | Subsection text reads:<br>Predictive modeling, a pre-payment claims process in CHAMPS, uses advanced screening technology to identify Medicaid claims with billing irregularities. Claims flagged by the predictive modeling process will undergo a detailed analysis to determine the next step(s) to be taken. This may include a review of medical records and/or past claims. Providers must submit the requested records within 30 days of the date on the request for documents letter to avoid denials for lack of documentation.<br>Requested records must be submitted through Documentation EZ Link using the Predictive Modeling Claim Documentation form (MSA-0004-EZ) or as an EZ Link attachment with code word "MDCHPM" and the Transaction Control Number (TCN) in the message subject line. (Refer to the Forms Appendix for a copy of MSA-0004-EZ. Refer to the Directory Appendix for Documentation EZ Link website information.) |
| | | Directory Appendix | Claim Submission/Payment | addition of:<br>Contact/Topic: Documentation EZ Link<br>Web Address: www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Documentation EZ Link<br>Information Available/Purpose: EZ Link training, instructions, and cover sheets |

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| | | Forms Appendix | | addition of form:<br>MSA-0004-EZ Predictive Modeling Claim Documentation |
| MSA 12-63 | 12/1/2012 | General Information for Providers | 7.1 Sanctioned Providers | In the 2nd paragraph, text in the 2nd, 3rd, and 4th sentences was revised to read:<br>Notice of a provider's sanction is provided in a cumulative list of sanctioned providers and is available on the MDCH website. |
| MSA 12-61 | 12/1/2012 | Hospital Reimbursement Appendix | 2.1 Diagnosis Related Group Assignment | The 7th (last) paragraph was revised to read:<br>Use of a specific Grouper is determined by the patient's discharge date. |
| MSA 12-60 | 12/1/2012 | Nursing Facility Cost Reporting & Reimbursement | 4.8.D. Extended Period Cost Report | The 1st paragraph was revised to read:<br>A provider may submit a request for a cost reporting period of more than 12 months but not greater than 13 months if:<br>• the provider is terminating Medicaid Program participation; or<br>• the facility is closing.<br>In the 3rd paragraph, the 2nd sentence was revised to read:<br>Examples include requests in which: ... |
| MSA 12-59 | 12/1/2012 | Hospital | 3.19.A. Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation<br>(new subsection) | Subsection text reads:<br>To reduce the rate of elective, non-medically indicated delivery prior to 39 weeks completed gestation, it is the expectation of MDCH that each Medicaid-enrolled birthing hospital in Michigan utilizes elective delivery evidence-based guidelines (EBGs).<br>To ensure that each Medicaid-enrolled birthing hospital in Michigan utilizes elective delivery EBGs, each hospital must have a completed Medicaid Enrolled Birthing Hospital Agreement for Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation (MSA-1755) on file with MDCH. A copy of the form is provided in the Forms Appendix and is also available on the MDCH website. (Refer to the Directory Appendix for website information.) |

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| | | Acronym Appendix | | Addition of:<br>EBG – Evidence-Based Guidelines |
| | | Forms Appendix | | Addition of:<br>MSA-1755 Medicaid Enrolled Birthing Hospital Agreement for Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation |
| MSA 12-58 | 12/1/2012 | Laboratory | Section 3 – Reimbursement Limitations | The 2nd paragraph was revised to read:<br>A beneficiary cannot be charged for any covered laboratory procedures, including those that are determined to be non-medically necessary.<br>The 3rd, 4th, 5th and 6th paragraphs were removed.<br>The 7th (last) paragraph was revised to read:<br>When billing Medicaid for services rendered, the DOS indicated on the claim must be the date the specimen is collected. |
| MSA 12-57 | 12/1/2012 | General Information for Providers | 7.3 Out of State/Beyond Borderland Providers | The following was inserted after the 5th paragraph:<br>**Note for Nursing Facilities:** The only borderland nursing facilities that are allowed to enroll with Michigan Medicaid are those facilities where Michigan beneficiaries were admitted to the facilities prior to October 1, 2007 or were admitted where placement was approved by Medicaid due to closure of a Michigan facility. To ensure that these borderland nursing facilities serving Michigan Medicaid beneficiaries have a current standard Health Survey, a Life Safety Code Survey, and a current facility license, MDCH requires this information be sent to MDCH each year. The review of survey and license information by MDCH will occur prior to December 31 of each year. This information must be received by the Medicaid Provider Enrollment Unit by November 1 of each year so the borderland nursing facility Medicaid enrollment continues. (Refer to the Directory Appendix for contact information.) |

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|---|---|---|---|---|
| | | Directory Appendix | Nursing Facility Resources | Addition of:<br>Contact/Topic: Provider Enrollment Contact Information for Borderland Nursing Facilities<br>Phone #/Fax #: Phone = 517-241-7186; Fax = 517-241-8970<br>Mailing/E-Mail Address:<br>MDCH/Medicaid Payments Division<br>Provider Enrollment Unit<br>P.O. Box 30238<br>Lansing, MI 48909<br>providerenrollment@michigan.gov<br>Information Available/Purpose: For submission of annual Health Survey, Life Safety Code Survey, and current facility license. |
| MSA 12-42 | 8/31/2012 | Medicaid Provider Manual Overview | 1.1 Organization | In the table, Physician Assistants was added to the list of Affected Providers for the Practitioner Chapter. |
| | | General Information for Providers | 12.1 Billing Provider | In the 1st paragraph, the 2nd sentence was revised to read:<br>... provider NPI numbers to be reported in any applicable provider loop or field (e.g., billing, rendering, referring, servicing, supervising, attending, etc.) on the claim. |
| | | Billing & Reimbursement for Institutional Providers | 2.3 Reporting Provider NPI | In the 4th paragraph, the 1st sentence was revised to read:<br>MDCH NPI claim editing will be applied to the billing, rendering, attending, supervising, and referring providers as applicable. |
| | | Billing & Reimbursement for Professionals | Section 1 – General Information | In the 2nd paragraph, Physician Assistants was added to the bullet list. |

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| | | | 2.3 Reporting Provider NPI | In the 1st paragraph, the 1st sentence was revised to read:<br>... NPI provider numbers to be reported in any applicable provider loop or field (e.g., billing, rendering, referring, supervising, etc.) on the claim.<br>In the 4th paragraph, the 1st sentence was revised to read:<br>MDCH NPI claim editing will be applied to the billing, rendering, attending, supervising, and referring providers as applicable. |
| | | | 2.3.B. Rendering Provider | Text after the 2nd sentence was revised to read:<br>Claims for services rendered by non-physician practitioners (e.g., physician assistants and nurse practitioners) must be billed under the non-physician practitioner's NPI and include the NPI of the supervising physician as applicable. |
| | | | 2.3.D. Supervising Provider<br>(new subsection) | New subsection text reads:<br>The supervising physician NPI is a claim editing requirement which must be included on claims when physician services are rendered by an enrolled non-physician practitioner, such as a physician's assistant or nurse practitioner. Physician supervision and oversight must be consistent with Michigan Public Act 368 of 1978, as amended. The supervising physician must be enrolled with the program. |
| | | Federally Qualified Health Centers | 1.5 Nonenrolled Provider Services | In the 1st paragraph, the 1st sentence was revised to read:<br>Professional services provided by FQHC clinical social workers and clinical psychologists are reimbursed under the PPS. |
| | | Laboratory | Section 1 – General Information | In the 2nd paragraph, the 1st sentence was revised to read:<br>Medicaid reimburses laboratories only for those services it is certified by the Clinical Laboratory Improvement Amendments (CLIA) to perform and for those services ordered by physicians (MD or DO), physician assistants (PAs), certified nurse practitioners (CNPs), certified nurse midwives (CNMs), podiatrists (DPMs), or dentists. |

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| | | Practitioner | 1.2 Billing for Delegated Services | Subsection was deleted, and following subsections were re-numbered.<br>(**Note:** Relevant billing information is now included in or combined with information in the Billing & Reimbursement for Professionals Chapter and in the Physician Delegation and Supervision subsection of the Practitioner Chapter.) |
| | | | 1.8 Physician Delegation and Supervision | The following text was added at the end of the 1st paragraph:<br>Delegated and supervised services rendered by non-physician practitioners (e.g., physician assistants and nurse practitioners) must be billed under the non-physician practitioner's NPI and include the NPI of the supervising physician as applicable. |
| | | | 20.5 Authorized Practitioners | The 4th bullet point was revised to read:<br>• Physician's Assistant |
| | | | Section 22 – Physician's Assistant | The following text was inserted after the 1st paragraph:<br>To enroll as a Medicaid provider, physician assistants must complete an on-line application through CHAMPS and are to be enrolled as Rendering/Servicing-Only providers. Physician assistants are not eligible for direct Medicaid reimbursement. Payment for services rendered by a physician's assistant will be made to the delegating/supervising physician, group or billing provider NPI. The supervising physician is responsible for the services performed by the physician's assistant.<br>The 4th paragraph was deleted. |
| | | | Section 26 – Nurse Practitioner | This section was revised in its entirety; subsections separate information into specific subject matter. |
| | | | 26.1 General Information<br>(new subsection) | Subsection text reads:<br>Medicaid covers the services of a nurse practitioner (NP) when they are performed while working in collaboration with a physician. Medicaid covers NP services only if:<br>• the services would be covered if furnished by a physician;<br>• the services are not otherwise excluded from coverage; and,<br>• the NP is legally authorized to perform the services under state law. |

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| | | | | NP services are subject to the limitations that apply to physician services. Certain services, such as long-term care facility visits, consultations, and initial hospital care, may be restricted to physicians by program policy or federal and state statues and may not be covered for NPs.<br><br>Professional services are only covered when the NP has personally performed the services and no facility or other provider charges, or is paid, any amount for the furnishing of the professional service. Services provided jointly by an NP and the supervising physician are covered for only one practitioner.<br><br>Determination of the medical necessity and appropriateness of services is the responsibility of the NP/physician based on the terms of their collaborative agreement. |
| | | | 26.2 Enrollment of Nurse Practitioners<br><br>(re-numbered -- previously numbered 26.1) | Subsection text revised to read:<br><br>Nurse practitioners who render services to Medicaid beneficiaries must be enrolled providers. In order for an NP to enroll, he/she must meet the following requirements and enroll as either a Rendering/Servicing-Only Provider or an Individual/Sole Provider and:<br><br>• meet all state qualifications for nurse practitioners;<br>• have an ambulatory-based practice;<br>• attest to the type of nurse practice engaged in, such as pediatric, family, geriatric, adult, etc.; and<br>• if engaged in family or pediatric nurse practice, continue to provide proof of certification as a family nurse practitioner or a pediatric nurse practitioner by the appropriate accepted national credentialing body. (Refer to Michigan Rule 338.10404 [3].) |
| | | | 26.2.A. Rendering/Servicing-Only Nurse Practitioners<br><br>(new subsection) | Subsection text reads:<br><br>A physician-employed NP who renders services only under the physician's delegation and supervision under an employment relationship or agreement is required to be an enrolled provider and uniquely identified on claims for services. He/she may enroll as a Rendering/Servicing-Only Provider, and payment for these services will be made to the employing, supervising physician or physician group. |

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| | | | 26.2.B. Individual/Sole Provider Nurse Practitioners<br>(new subsection) | Subsection text reads:<br>In order for an NP to enroll and receive direct reimbursement as an Individual/Sole Provider, he/she must comply with the following requirements:<br>• provide services according to the terms of a written collaborative practice agreement in place with a physician. (Refer to the Collaborative Practice Agreement subsection for additional information.);<br>• complete the appropriate enrollment forms and a Nurse Practitioner/Physician Agreement (DCH-1575). (A copy of the form is provided in the Forms Appendix and is also available on the MDCH website. Refer to the Directory Appendix for website information.); and<br>• once enrolled, the individual/sole provider NP may submit claims to MDCH directly if the beneficiary is in FFS Medicaid. For beneficiaries enrolled in a MHP, the NP must negotiate provider terms and payment arrangements with each individual MHP. |
| | | | 26.3 Collaborative Practice Agreement<br>(re-numbered -- previously numbered 26.2) | The 1st paragraph was revised to read:<br>This is a formal document to be completed by Individual/Sole Provider NPs seeking direct reimbursement. It describes terms under which the NP and the physician deliver covered medical services. It is mutually developed or approved as satisfactory to both professionals involved and describes the types of services to be provided and any criteria for referral and consultation. This agreement must be available to MDCH upon request. Services must be delivered within each practitioner's scope of practice as allowed by federal regulations and state law. |
| | | Rural Health Clinics | 2.2 Nonenrolled Providers | The 1st sentence was revised to read:<br>Professional services provided by RHC clinical social workers and clinical psychologists are reimbursed under the RHC PPS. |
| | | Tribal Health Centers | 2.2 Nonenrolled Providers | The 1st sentence was revised to read:<br>Professional services provided by THC clinical social workers and clinical psychologists are reimbursed under the THC PPS. |

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| | | | 3.1 Covered Services | In the 3rd paragraph, in the table under "Physician's Assistant", text was revised to read:<br>Physician's assistant services must comply with coverage and limitations published in the Practitioner Chapter and in MDCH Bulletins. |
| | | Forms Appendix | | Addition of:<br>DCH-1575 Nurse Practitioner/Physician Agreement |
| MSA 12-35 | 8/15/2012 | Hospital Reimbursement Appendix | 8.4 GME Funds Pool | In the 2nd paragraph, the footnote was revised to read:<br>*GME Funds Pool size: $52,565,600 |
| | | | 8.5 Primary Care Pool | The footnote was revised to read:<br>* Primary Care Pool size: $10,322,700 |

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Michigan Department of Community Health

# Supplemental Bulletin List

## January – March 2013

**The following is a list of Medicaid policy bulletins issued on and after December 1, 2012 that supplement the online version of the Medicaid Provider Manual. The list is updated as additional policy bulletins are issued. NOTE: As stated in MSA Bulletin 09-60 issued December 1, 2009, this list includes only those bulletins which have not been formally incorporated into the Medicaid Provider Manual maintained on the MDCH website. The updated list showing all bulletins for the current calendar year is posted on the MDCH website along with the Medicaid Provider Manual.**

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

| DATE ISSUED | BULLETIN NUMBER | TOPIC | AFFECTED PROVIDERS | COMMENTS |
|---|---|---|---|---|
| 2/15/2013 | MSA 13-03 | Adult Benefits Waiver Enrollment | All Providers | |
| 2/15/2013 | MSA 13-02 | Establishment of Fiscal Year (FY) 2013 Rural Access Pool | Hospitals | |
| 1/25/2013 | MSA 13-01 | Correction to Effective Date for Bulletin MSA 12-64 | Maternal Infant Health Providers, Medicaid Health Plans | |
| 12/28/2012 | MSA 12-69 | Post-Payment Review Hospital Audit Contract | Hospitals | |