MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 13-15

Distribution: All Providers

Issued: June 1, 2013

Subject: Updates to the Medicaid Provider Manual; Supplemental Bulletin List; Injectable Carve-out; Beneficiary Monitoring Program; ICD-10 Project Update

Effective: As Indicated

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

Updates to the Medicaid Provider Manual

The Michigan Department of Community Health (MDCH) has completed the July 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.

Supplemental Bulletin List

Effective July 1, 2013, all Medicaid provider bulletins not incorporated into the Michigan Medicaid Provider Manual will be included on a Supplemental Medicaid Bulletins list on the MDCH website at www.michigan.gov/medicaidproviders >>Policy and Forms >>Medicaid Provider Manual. This list will be updated each month as new Medicaid Provider Bulletins are issued. Bulletins will be removed from the list when they are incorporated into the Provider Manual. A separate Supplemental Bulletin attachment is no longer distributed with the quarterly update bulletins.

Injectable Carve-out

Effective for dates of service on and after July 1, 2013, injections Aripiprazole (J0400), Aripiprazole (Abilify Maintena) (J3490), Chlorpromazine Hydrochloride (J3230), Diazepam (J3360), Prochlorperazine Edisylate (J0780), and Phenobarbital Sodium (J2560) are being carved out of the Community Mental Health Services Program (CMHSP), Pre-Paid Inpatient Health Plan (PIHP) and Medicaid Health Plan (MHP) contracts. These codes should be billed as a Fee For Service benefit.

Beneficiary Monitoring Program

Effective April 1, 2013, beneficiaries enrolled in a Medicaid Health Plan (MHP), as well as beneficiaries enrolled in Medicaid Fee For Service (FFS), are eligible for Beneficiary Monitoring Program (BMP) enrollment. The CHAMPS Eligibility Inquiry response (described in Bulletin MSA 13-07) which provides information about the beneficiary's BMP Authorized Provider(s) is only available for beneficiaries enrolled in FFS and for MHP beneficiaries enrolled in BMP receiving services carved out of the MHP benefit. For services provided by a MHP to a beneficiary enrolled in BMP, Authorized Provider information must be obtained from the MHP.

The upgraded BMP also includes the following features:

- Changes in beneficiary enrollment in the BMP now allow for tracking the beneficiary so they remain in the BMP for the minimum time period regardless of change in enrollment status (e.g., change from FFS to managed care, break in eligibility, incarceration, etc.). When a beneficiary in the BMP has a change in enrollment, responsibility for monitoring the beneficiary moves from MDCH to the MHP or vice versa.

- Responsibilities for all providers include verification of BMP enrollment before providing the service(s). Only those providers listed as a BMP Authorized Provider or having a current Beneficiary Monitoring Primary Provider Referral Notification/Request (form MSA-1302) will be reimbursed by Medicaid FFS for services provided.

- Only certain BMP Authorized Providers will be approved to prescribe drugs subject to abuse. These providers will be indicated with a 'Y' under the 'Send to PBM' field within the CHAMPS Eligibility Inquiry response.

It is the responsibility of the BMP Authorized Provider to notify MDCH when a beneficiary in the BMP is discharged from their practice.

ICD-10 Project Update

MDCH continues to transition its policies, procedures and information systems to support the ICD-10 code sets on all HIPAA transactions by the federally mandated compliance date of October 1, 2014. Prior to implementing the new ICD-10 processing functions into its systems, MDCH will present Medicaid providers and trading partners with an opportunity to test their ability to communicate with MDCH using ICD-10 coded transactions. These testing activities are scheduled to begin by October of 2013 and will be designed to help providers ensure that their remediation efforts to prepare for the transition to ICD-10 have resulted in the creation of transactions that can be processed successfully.

Any questions regarding ICD-10 implementation should be directed to MDCH-ICD-10@michigan.gov. Providers should continue to frequently check the MDCH website at www.michigan.gov/5010icd10 for ICD-10 updates, including additional details regarding testing opportunities and procedures in upcoming months. Providers are encouraged to check for available ICD-10 trainings on the MDCH website at www.michigan.gov/medicaidproviders -- under "Hot Topics", click on "Medicaid Provider Training Sessions."

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
July 2013 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		Due to re-organization and re-naming, changes consist of: • "MDCH Appeals Section" changed to read "Michigan Administrative Hearing System" • "State Office of Administrative Hearings and Rules" and/or "SOAHR" changed to read "Michigan Administrative Hearing System" and/or "MAHS" • "the Appeals Section for MDCH" changed to read "Michigan Administrative Hearing System " and/or "MAHS"	Update.
Throughout the Manual		References to "powered flotation" and "power flotation" were revised to read "powered air flotation."	Update.
Throughout the Manual		References to "Bureau of Health Services", "Bureau of Health Systems" and/or "BHS" were revised to read "Bureau of Health Care Services" and/or "BHCS."	Update due to re-naming.
Throughout the Manual		References to "Drug Enforcement Agency" were revised to read "Drug Enforcement Administration."	Correction.
Throughout the Manual		References to "Centers for Disease Control" were revised to read "Centers for Disease Control and Prevention."	Correction.
Throughout the Manual		References to "percentage of charge" were revised to read "percent of charge."	Clarification/consistency of use in terminology.
Throughout the Manual		References to "Office of Financial and Insurance Regulation" and/or "OFIR" were revised to read "Department of Insurance and Financial Services" and/or "DIFS."	Update due to re-organization.

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

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CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	8.1 Free Choice	Text was revised to read: Beneficiaries are assured free choice in selecting an enrolled licensed/certified provider to render services unless they are patients in a state-owned and -operated psychiatric facility, enrolled in a Medicaid Health Plan (MHP) or County Health Plan (CHP) (including PLUS CARE), or otherwise specified.	Clarification.
General Information for Providers	9.1.A. Admissions/ Readmissions/Transfers that Require a PACER Number	In the 2nd bullet point, the 2nd sentence was revised to read: NOTE: If a beneficiary is readmitted to the same hospital within 15 days for a related (required as a consequence of the original admission) condition, Medicaid considers the admission and the related readmission as one episode for payment purposes. The related admissions must be combined on a single claim.	Change made to clarify the intent of the policy.
General Information for Providers	9.4 Post-Payment Review of Transfers and Readmissions	Subsection was deleted. Following subsection was re-numbered.	New post-payment review hospital contract obsoletes this information.
General Information for Providers	9.6 Termination of Benefits (new subsection)	Subsection text reads: The hospital's Utilization Review Committee may issue a notice of noncoverage to the beneficiary if it determines that the admission or continued stay in the hospital is not medically necessary. The notice should be substantially similar to the sample letters contained in the Forms Appendix of this manual.	Information relocated for more appropriate placement (previously Hospital Chapter, 4.8).

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		If the beneficiary or beneficiary's representative disagrees with the notice, the beneficiary or representative may contact the ACRC to appeal the decision. If the ACRC previously issued an adverse determination for the period of hospitalization covered by the notice, the ACRC informs the beneficiary of concurrence with the hospital decision. If the ACRC did not previously issue an adverse determination for the period, a review of the medical record is conducted. The ACRC contacts the hospital to obtain a copy of the medical record. An ACRC physician advisor reviews the medical necessity of the admission or continued stay. The ACRC reviews and issues a decision on the case within three business days of receipt of the hospital's Utilization Review Committee notice of noncoverage and the beneficiary's supporting medical records. If issued, the notice is the responsibility of the hospital's Utilization Review Committee and is not related to any decision that may have been rendered by the ACRC on the case. The decision must be based on the findings of the Utilization Review Committee and not on the determination of the ACRC. As with any benefit denial, the beneficiary or beneficiary's representative may request an administrative hearing. The Michigan Administrative Hearing System (MAHS) provides an administrative hearing to appellants requesting a hearing who do not agree with a decision made by MDCH or a MDCH contracted agency (i.e., any agency, organization, or health plan contracted by MDCH) that either determines eligibility for a MDCH program, or delivers a service provided under a MDCH program to a beneficiary, patient or resident. MAHS issues timely, clear, concise and legally accurate hearing decisions and orders. The MAHS Policy and Procedures Manual explains the process by which each different type of case is brought to completion. The MAHS manual is available on the MDCH website. (Refer to the Directory Appendix for website information.)	
General Information for Providers	15.4 Availability of Records	In the 2nd paragraph, the 2nd sentence was revised to read: (Failure to make requested records available for examination and duplication and/or extraction through the method determined by authorized agents of the state or federal government may result in the provider's suspension and/or termination from Medicaid.)	Clarification.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Revisions to the table after the 2nd paragraph are noted below: **Benefit Plan ID: ABW-ESO** Funding Source: revised to read "XIX" **Benefit Plan ID: ABW-MC** Funding Source: revised to read "XIX" **Benefit Plan ID: AUT (addition)** Benefit Plan Name: Autism Related Services – Managed Care Benefit Plan Description: This plan is for beneficiaries who are at least 18 months and less than 6 years of age who are diagnosed with Autism Spectrum Disorder. The benefit includes Applied Behavioral Analysis services at two different levels: • Level 2, or EIBI, is a higher level of benefit for beneficiaries who have Autistic Disorder • Level 1, or ABI, is available to beneficiaries who do not qualify for Level 2 Type: Managed Care Organization Funding Source: XIX Covered Services: MH	General updates.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		Benefit Plan ID: BMP Benefit Plan Description: revised to read: The objectives of the Beneficiary Monitoring Program (BMP) are to promote quality health care, identify beneficiaries that may be mis/over-utilizing Medicaid benefits, modify improper utilization of services through education and monitoring, and ensure that beneficiaries are receiving medically necessary services. Beneficiaries remain in BMP through changes in eligibility, including enrollment into managed care. For beneficiaries with managed care, the Medicaid Health Plan (MHP) coordinates the member's care. **Benefit Plan ID: HK-EXP** Covered Services: addition of Service Type Codes 48 and 50 **Benefit Plan ID: INCAR-ESO** Benefit Plan Name: revised to read "Incarceration –Emergency Services (No Benefits)" Benefit Plan Description: revised to read "This program will not provide benefits while an otherwise ESO eligible member is incarcerated." Covered Services: revised to read "N/A" **Benefit Plan ID: INCAR-MA-E** Benefit Plan Name: revised to read "Incarceration – MA Emergency Services (No Benefits)" Benefit Plan Description: revised to read "This program will not provide benefits while an otherwise MA-E eligible member is incarcerated." Covered Services: revised to read "N/A"	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		Benefit Plan ID: MA Benefit Plan Description: The 2nd sentence was revised to read "Once assigned to a Managed Care Organization, the health plan is the primary payer. Covered Services: addition of Service Type Codes 48 and 50 **Benefit Plan ID: MA-MC** Benefit Plan Description: revised to read: Full Medicaid for Managed Care Organization enrollment. This capitated plan will be set to a higher priority than MA (fee-for-service). Some services not covered under this plan could be covered in MA. Covered Services: addition of Service Type Codes 48 and 50 **Benefit Plan ID: MI-CHOICE** Benefit Plan Description: revised to read: The MI Choice waiver is a program that provides home and community-based services for aged and other disabled adults who meet the nursing facility level of care. The program's goal is to provide long-term services and supports that allow persons to remain at home or similar community-based settings. These persons qualify for nursing facility services but choose to receive services in their home. MI Choice beneficiaries are eligible to receive Medicaid state plan services but are excluded from enrollment in a Medicaid Health Plan. **Benefit Plan ID: MIChild** Covered Services: addition of Service Type Codes 48 and 50 **Benefit Plan ID: MOMS** Covered Services: addition of Service Type Codes 48 and 50	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		Benefit Plan ID: PACE Covered Services: addition of Service Type Codes 48 and 50 **Benefit Plan ID: QMB** Benefit Plan Description: The 3rd sentence was revised to read "Under certain income limits, Medicaid pays for Medicare Part B premiums, deductibles and co-insurance." **Benefit Plan ID: SED** Benefit Plan Description: The 1st sentence was revised to read " … for children under age 21." **Benefit Plan ID: SED-DHS** Benefit Plan Description: The 1st sentence was revised to read " … for children under age 21." **Benefit Plan ID: TMA-PLUS** Covered Services: addition of Service Type Codes 48 and 50	
Coordination of Benefits	Section 2 – Categories of Other Insurance	The 1st bullet point was revised to read: • Commercial health insurance carriers (i.e., managed care carriers [MCC], preferred provider organizations [PPO], point of service organizations [POS], health maintenance organizations [HMO], long-term care [LTC] insurance policies), traditional indemnity policies, and military/veteran insurance (i.e., TRICARE and the Civilian Health and Medical Program of the Department of Veterans Affairs [CHAMPVA]).	Revised to include military/veteran insurance as a form of other insurance.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Coordination of Benefits	2.1 Commercial Health Insurance	Subsection title was revised to read "Commercial Health Insurance, Traditional Indemnity Policies, and Military/Veteran Insurance." In the 1st paragraph, the 1st sentence was revised to read: If a Medicaid beneficiary is enrolled in a commercial health insurance plan or is covered by a traditional indemnity policy or military/veteran insurance, the rules for coverage by the commercial health insurance, traditional indemnity policy, or military/veteran insurance must be followed. The 2nd paragraph was revised to read: Beneficiaries must use the highest level of benefits available to them under their policy. Medicaid is not liable for payment of services denied because coverage rules of the primary health insurance were not followed. For example, Medicaid does not pay the point of service sanction amount for the beneficiary electing to go out of the preferred provider network. Medicaid is, however, liable for Medicaid-covered services that are not part of the primary health insurance coverage. In the chart following the 2nd paragraph, under "PA is required for the following:", the 1st bullet point was revised to read: • PA is required for cases where the other insurance benefit has been exhausted or the service/item is not a covered benefit. In the 4th paragraph, the 1st sentence was revised to read: MDCH payment liability for beneficiaries with other insurance is the lesser of the beneficiary's liability ...	Revised to include other forms of insurance.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Coordination of Benefits	2.6.F. Medicaid Liability	The 6th paragraph was revised to read: MDCH does not pay for services denied by Medicare or other insurance plans due to noncompliance with Medicare or other insurance plan requirements. If the provider's service would have been covered and payable by Medicare or the other insurance plan but some requirement of the plan was not met, MDCH will deny the claim. The provider and the beneficiary both have equal responsibility for complying with Medicare or the other insurance plan requirements. In the 12th paragraph, the 2nd sentence was revised to read: Refer to the Commercial Health Insurance, Traditional Indemnity Policies, and Military/Veteran Insurance subsection of this chapter for ...	Change to maintain language consistency throughout chapter.
Billing & Reimbursement for Institutional Providers	4.1 Authorization of Admissions and Services	Text after the table in the 2nd paragraph was revised to read: **CSHCS Exceptions:** • Prior to October 1, 2012, beneficiaries with CSHCS coverage were excluded from enrollment in a MHP and the following applied: ➢ When a beneficiary was enrolled in CSHCS, he/she was disenrolled from the MHP. ➢ Upon review, MDCH may have initiated a retroactive disenrollment from the MHP effective the first day of the month in which CSHCS medical eligibility was determined. ➢ Responsibility of payment transferred from the MHP to FFS on the effective date of the disenrollment. • After October 1, 2012, Medicaid beneficiaries who become eligible for CSHCS who are enrolled in an MHP will no longer be disenrolled from the MHP. Providers are advised to check the eligibility response for changes in enrollment status prior to billing. (Refer to the Beneficiary Eligibility Chapter for additional information.)	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	6.2.C. Special Circumstances for Hospital Readmissions and Transfers	Under "Readmission within 15 days to the Same Hospital (Related Admission), the 1st sentence was revised to read: If a beneficiary is readmitted to the same hospital within 15 days for a related (required as a consequence of the original admission) condition, Medicaid considers the admission and the related readmission as one episode for payment purposes. The related admissions must be combined on a single claim.	Change was made to maintain consistency with language.
Billing & Reimbursement for Institutional Providers	6.6 Transplants	In the 1st paragraph, the 2nd bullet point was revised to read: • The letter of authorization for the transplant from the Office of Medical Affairs (OMA) or MHP must be attached to all applicable transplant claims; otherwise, payment is denied.	The word "applicable" was added because PA is not needed for cornea or kidney transplants.
Billing & Reimbursement for Institutional Providers	8.13 Medicare Part B Coinsurance and Deductible Amounts	In the 4th paragraph, text was revised to read: ... 0275, 0276, 0300- 0359, 0400-0409 ...	addition of revenue code 0300
Billing & Reimbursement for Institutional Providers	11.1 Billing Instructions for Hospice Claim Completion	In the 5th bullet point, text after the 4th sentence was revised to read: When a beneficiary resides in a VDCU/Dialysis Unit under which the VDCU has a special agreement with Medicaid and elects hospice, a prior authorization (PA) number for hospice is not required.	Correction.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Professionals	5.1 Inpatient Hospital Admissions and Services	Text after the table in the 2nd paragraph was revised to read: **CSHCS Exceptions:** • Prior to October 1, 2012, beneficiaries with CSHCS coverage were excluded from enrollment in a MHP and the following applied: ➢ When a beneficiary was enrolled in CSHCS, he/she was disenrolled from the MHP. ➢ Upon review, MDCH may have initiated a retroactive disenrollment from the MHP effective the first day of the month in which CSHCS medical eligibility was determined. ➢ Responsibility of payment transferred from the MHP to FFS on the effective date of the disenrollment. • After October 1, 2012, Medicaid beneficiaries who become eligible for CSHCS who are enrolled in an MHP will no longer be disenrolled from the MHP. Providers are advised to check the eligibility response for changes in enrollment status prior to billing. (Refer to the Beneficiary Eligibility Chapter for additional information.)	Update.
Home Health	6.1.I. Postpartum/ Newborn Follow-up Nurse Visit	The 4th (last) paragraph was removed.	Obsolete information.
Hospital	4.8 Termination of Benefits	Subsection subject/text was relocated to the General Information for Providers chapter. Following subsection was re-numbered.	Information relocated for more appropriate placement.
Hospital Reimbursement Appendix	7.2.B. Small Hospital DSH Pool	Subsection was deleted.	This DSH pool is no longer in use. Update to reflect information reported in bulletins MSA 10-37 and MSA 10-57.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	12.3 Appeal Process	References to "bureau conference" were revised to read "conference."	Update.
Hospital Reimbursement Appendix	12.5 State Hospital Appeal Panel	References to "bureau conference" were revised to read "conference."	Update.
Maternal Infant Health Program	Section 3 – Reimbursement	In the 2nd paragraph, the 2nd sentence was revised to read: For beneficiaries with other insurance, refer to the Coordination of Benefits chapter of this manual.	Change made for consistency of language used in the Coordination of Benefits chapter.
Maternal Infant Health Program	5.3 Operations and Certification Requirements	The 11th bullet point was revised to read: • Arrange transportation services when appropriate.	Clarification of current policy.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 3 – Definitions	Addition of: Resident - An individual who has been admitted to the provider's facility and has not been discharged.	Addition of missing information.
Practitioner	8.2 Delivery	The 1st sentence was revised to read: Includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, and delivery.	Clarification.
Practitioner	12.11 Destruction of Lesions	Subsection was re-located to the Surgery – Special Considerations section (re-numbered as 13.4). Following subsection was re-numbered.	More appropriate heading/location.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	13.4 Destruction of Lesions (new subsection)	Text reads: Medicaid covers destruction of lesions by methods such as electrocautery, cryocautery, laser, and surgery. Coverage of the surgical destruction of lesions that involves more extensive procedures is limited to the hospital/facility setting. Less extensive procedures are covered in the office/non-facility setting. (Refer to the MDCH Practitioner and Medical Clinic Database to determine which procedures require a hospital/facility setting for coverage and which procedures are covered in the office/non-facility setting.) If a repeat procedure to the same lesion is necessary, it is covered as an office visit. Chemocautery or chemical destruction of any lesion, such as the use of a nitrate stick or podophyllin, is covered as a part of the office visit. Following subsections were re-numbered.	Subject text was relocated from 12.11 for more appropriate heading/location.
School Based Services	2.1 Individuals with Disabilities Education Act Assessment and IEP/IFSP Development, Review and Revision	The following information was added under "Procedure Codes": • **96110** –Developmental screening, with interpretation and report, per standardized instrument form. (Used by the physician, psychologist or social worker billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).) • **96111** – Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments), with interpretation and report. (Used by the physician, psychologist or social worker billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), or the IDEA evaluation (HT).)	Added to resolve discrepancy with database information.

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	2.2.B. Orientation and Mobility Services	The following information was removed from "Procedure Codes": • **G9041** – Rehabilitation services for low vision by qualified occupational therapist, direct one-on-one contact, each 15 minutes. • **G9042** – Rehabilitation services for low vision by certified orientation and mobility specialist, direct one-on-one contact, each 15 minutes.	Codes were end dated as of 12/31/2011.
Directory Appendix	Eligibility Verification	Under "CHAMPS Eligibility Inquiry", the following website was added for Benefit Plan information: www.michigan.gov/medicaidproviders >> CHAMPS >> Resources >> Benefit Plan Handout & Service Type Codes	Update.
Directory Appendix	Billing Resources	Under "Automated Billing Unit/Electronic Billing Resources", the fax number was revised to read 517-335-3766.	Update.
Directory Appendix	Appeals	Under "Appeals (Beneficiary)": • phone numbers were revised to read 877-833-0870 or 517-335-2484 • fax number was revised to read 517-373-4147 Under "Appeals (Provider)": • phone numbers were revised to read 877-833-0870 or 517-335-4900 • fax number was revised to read 517-241-7973 • mailing address - 2nd line was revised to read P.O. Box 30807	Update.
Directory Appendix	Reporting Fraud, Abuse, or Misuse of Services	Under "Welfare Fraud Hotline", the Mailing Address was revised to read: Department of Human Services Office of Inspector General 235 S. Grand, Ste. 218 Lansing, MI 48933	Clarification.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Glossary Appendix		Addition of: Ambulatory Payment Classification (APC) - The Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classification (APC) is a reimbursement method representing groups of outpatient visits according to clinical characteristics and costs associated with the diagnoses and the procedures rendered known as APCs.	
Glossary Appendix	Physician (MD or DO)	Definition was revised to read: An individual licensed under the Michigan Public Health Code (1978 P.A. 368) to engage in the practice of medicine or osteopathic medicine and surgery.	Clarification.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 13-12	4/1/2013	Practitioner Reimbursement Appendix	1.3 Injectables	The 2nd paragraph was re-formatted as a textbox, and the 1st sentence was revised to read: Effective for dates of service January 1, 2012 through March 31, 2013 only, modified methodology pricing places certain lower cost injectable drugs in classes with therapeutic alternatives at the maximum allowable cost.
MSA 13-11	4/1/2013	Mental Health/ Substance Abuse	14.3 Covered Waiver Services	The following service/description was added to the table: **Financial Management Services/Fiscal Intermediary Services** Healthcare Common Procedure Coding System (HCPCS) code "T2025" should be used to bill for this service. This is a "per month" service with a maximum unit of one per month. Financial Management Services/Fiscal Intermediary Services include, but are not limited to,: • Facilitation of the employment of service workers by the child's parent or guardian acting as the consumer's representative, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting; • Assuring adherence to federal and state laws and regulations; and • Ensuring compliance with documentation requirements related to management of public funds. The fiscal intermediary may also perform other supportive functions that enable the consumer – through his/her parent or guardian - to self-direct needed services. These functions may include helping the consumer's representative recruit staff (e.g., developing job descriptions, placing ads, assisting with interviewing); contracting with or employing providers of services; verification of provider qualifications (including reference and background checks); and assisting the consumer and his/her representative to understand billing and documentation requirements.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				This is a service that handles the financial flow-through of Medicaid dollars for children enrolled in the CWP who are using Choice Voucher arrangements. This CWP waiver service is available only to CWP consumers whose parent or guardian, serving as the consumer's representative, chooses to self-direct selected services through Choice Voucher arrangements. A CMHSP may terminate self-direction of services (and therefore Financial Management Services) when the health and welfare of the consumer is in jeopardy due to the failure of the consumer's representative to direct services and supports or when the consumer's representative consistently fails to comply with contractual requirements. A fiscal intermediary is an independent legal entity – organization or individual - that acts as the fiscal agent of the CMHSP for the purpose of assuring fiduciary accountability for the funds authorized to purchase specific services identified in the consumer's individual plan of service (IPOS). The fiscal intermediary receives funds from the CMHSP and makes payments authorized by the consumer's parent or guardian, as the consumer's representative. The fiscal intermediary acts as an employer agent when the consumer's representative directly employs staff or other service providers. The fiscal intermediary can be an agency or organization (e.g., financial management services agency, accounting firm, local ARC or other advocacy organization) or individual (e.g., accountant, financial advisor/manager, attorney). The fiscal intermediary must meet requirements as identified in the MDCH/CMHSP Managed Mental Health Supports and Services Contract – Attachment C3.4.4 Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program FY12 (and subsequent years) – Attachment P3 4.4.
		Mental Health/ Substance Abuse	14.3 Covered Waiver Services	In the table under "Respite Care", in the 1st paragraph, text after the 4th sentence was revised to read: ... All respite services are billed under HCPCS code T1005 – Respite Care Service 15 Min. – with modifiers as appropriate. The maximum respite allocation is 4,608 units (1,152 hours) per fiscal year.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Mental Health/ Substance Abuse Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix	Section 1 – General Information	The 1st sentence was revised to read: ... for children up to age 21 with serious emotional disturbance (SED) who are ...
			1.1 Key Provisions	The 1st sentence was revised to read: ... for children up to age 21 with SED who meet ...
			1.2 Eligibility	The last bullet point was revised to read: • ... the child can remain on the waiver up to their 21st birthday.
			2.10 Home Care Training, Non-Family (new subsection)	Subsection text reads: HCPCS Code S5116 – Non-Family Home Care Training/Session should be used to bill for this service. This service is reimbursable for up to four sessions per day but no more than 12 sessions per 90 days (i.e., three calendar months). A session can be of varying lengths of time but should meet the needs of the plan of service (POS); a billable session must be at least 45 minutes. This service provides coaching, training, supervision and monitoring of Community Living Supports (CLS) staff by clinicians (i.e., licensed psychologist, Master's level social worker, occupational therapist, physical therapist, speech therapist, or Child Mental Health Professional). Professional staff work with CLS staff to implement the consumer's POS, with focus on services designed to improve the child's/youth's social interactions and self-control by instilling positive behaviors instead of behaviors that are socially disruptive, injurious to the consumer or others, or that cause property damage. The activities of the professional staff ensure the appropriateness of services delivered by CLS staff and continuity of care. This service can be provided by more than one clinician in any given month, as the service provider is selected on the basis of his/her competency in the aspect of the POS on which training is conducted.

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<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td></td><td></td><td></td><td></td><td>Services must be provided by qualified providers who meet the requirements of, and in accordance with, 42 CFR §440.50 through §440.60(a) and other applicable state and federal laws or regulations.</td></tr>
<tr><td>MSA 13-10</td><td>4/1/2013</td><td>Medical Supplier</td><td>2.47 Wearable Cardioverter-Defibrillators
(new subsection)</td><td>Subsection text reads:
<table>
<tr><td>Definition</td><td>A wearable cardioverter-defibrillator (WCD) is an external device intended to perform the same tasks as an implantable cardioverter-defibrillator (ICD) without requiring an invasive procedure. It is considered a bridge to permanent ICD placement.

The WCD consists of a vest, worn continuously underneath clothing, and contains cardiac monitoring electrodes that deliver a counter shock. The vest is connected to a monitor with a battery pack and alarm module that interprets the cardiac rhythm and determines when a counter shock is necessary. An alarm module alerts the patient to certain conditions by lights or voice messages.</td></tr>
<tr><td>Standards of Coverage</td><td>The WCD may be considered medically necessary only as an interim treatment for patients at high risk of sudden cardiac arrest who:
• Have a left ventricular ejection fraction of 35% or less;
• Have a temporary contraindication to receiving an ICD (i.e., a systemic infection) at the current time; and</td></tr>
</table></td></tr>
</table>

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				<table><tr><td></td><td>• Are tentatively scheduled for an ICD placement procedure based on one of the following: ➢ Received treatment with the goal of an ICD placement and have been scheduled for the ICD placement within three months; or ➢ Had an ICD removed and have been scheduled for placement of another ICD once the contraindication has been treated. WCDs will not be covered for investigational procedures or patient preference.</td></tr><tr><td>**Documentation**</td><td>Documentation must include the following and be made available upon request unless otherwise noted in the Standards of Coverage and PA Requirements sections of this policy: • Diagnosis/medical condition related to the need for the item. • Specific item(s) required. • Medical reason why receiving an ICD is not currently plausible. • Current treatment plan and updated recommendations. • tentative scheduled date for ICD placement and/or date other ICD removed.</td></tr></table>

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				PA Requirements: Food and Drug Administration (FDA)-approved WCDs are covered under the Medicaid and CSHCS programs with prior authorization (PA). Requests for PA (form MSA-1653-B) may only be submitted by the beneficiary's managing cardiologist and must include a current treatment plan and updated recommendations. PAs are approved for 30 days at a time for a maximum of three months. For continued medical need beyond 30 days, a new PA request must be submitted documenting all of the following: • The beneficiary's response to and continued need for the WCD; • The anticipated date of the ICD procedure; and • The beneficiary's compliance with wearing the WCD. The compliance report must show 95% wear compliance and must be submitted with the PA request. Requests for continued PA beyond the maximum of three months will be considered on a case-by-case basis. **Payment Rules**: WCDs are rental only items. The rental fee includes the vest, monitoring electrodes, therapy electrodes and batteries. The batteries, garments and electrodes may be replaced due to normal use and wear of the WCD and require PA.
MSA 13-08	3/1/2013	Hospital Reimbursement Appendix	4.2 Terms of Service and Payment Between Noncontracting Hospitals and MHPs	Addition of a 3rd paragraph which reads: Refer to the Medicaid Health Plans Chapter of this manual for additional information about noncontracting hospitals and MHPs.

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		Medicaid Health Plans	2.6.C. Post-Stabilization Authorization Determinations (new subsection)	Subsection text reads: Non-contracted hospitals are required to obtain a patient post-stabilization authorization determination from the beneficiary's MHP prior to any treatment and after stabilization. A post-stabilization authorization determination refers to the process in which inpatient hospital admission or admission to observation status is authorized by the MHP after the beneficiary has been stabilized. (Note: This applies only to MHP beneficiaries who are not dually Medicare and Medicaid eligible. MHPs may not utilize prior authorization (PA) requirements for hospital services for dual Medicare and Medicaid eligible beneficiaries enrolled in an MHP and Medicare fee-for-service.) Hospitals are required to make and document all post-stabilization authorization requests by telephone call to the beneficiary's MHP prior to providing any treatment after stabilization. Hospitals must provide the MHP with all requested, necessary and current information, including the clinical status upon initial presentation, the clinical status after stabilization, and the initial treatment plan. This information must be provided in accordance with the Emergency Medical Treatment & Active Labor Act (EMTALA). The MHP is required to respond to post-stabilization requests within one hour of receipt of the telephone call and may not require hospitals to make additional phone calls if the initial phone call included all necessary and current clinical information. If the MHP does not respond within one hour, authorization for inpatient admission, payment and additional services is automatic.

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				Within one hour of the phone call in which the hospital provides the required clinical information noted above, the MHP must make an authorization decision which specifies the service authorized. The decision must be based on the information presented by the hospital at the time of the request rather than a list of pre-determined diagnoses that automatically authorize the patient for admission to observation status and not admission to the inpatient hospital. The MHP may not indicate that observation or admission will be authorized depending upon the clinical outcomes, and the MHP may not subsequently reverse an authorization decision based upon the clinical outcomes or length of time the patient remains in inpatient status. If the hospital and MHP are unable to reach agreement on an authorization decision at the time of the request, the hospital and the MHP must arrange a discussion between physicians in order to resolve the dispute. The MHP contract requires MHPs to provide twenty-four (24) hour, seven (7) day-a-week availability for post-stabilization authorization requests. Hospitals may not wait until the next business day after stabilization to call for authorization. If the hospital does not call for authorization after stabilization prior to providing additional services, the MHP may review the clinical record at the time of request for authorization or payment to determine if inpatient hospital admission or admission to observation status was clinically appropriate.
MSA 13-07	3/1/2013	Beneficiary Eligibility	2.1 Benefit Plans	Revisions are included in the July 2013 Technical Changes.
		Beneficiary Eligibility	2.6 Special Programs – Beneficiary Identification	The following information (5th line) was removed from the table: Benefit Plan ID: BMP Program/Eligibility Type: Beneficiary Monitoring Program – Restricted Primary Provider Control

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		Beneficiary Eligibility	Section 8 - Beneficiary Monitoring Program (Section/subsections were revised/reformatted in their entirety.)	Section text reads: State and federal regulations require the Medicaid program to conduct surveillance and benefits utilization review to ensure the appropriate amount, scope, and duration of medically necessary services are being provided to program beneficiaries. The Beneficiary Monitoring Program (BMP) is in place to closely monitor program usage and to identify beneficiaries who may be over-utilizing and/or misusing their Medicaid services and benefits. The purpose of the Beneficiary Monitoring Program is to: • Promote quality health care; • Prevent harmful practices, such as duplication of medical services, drug interaction, and possible drug abuse; • Identify beneficiaries for review who may over-utilize and/or misuse their Medicaid benefits; • Analyze beneficiary patterns of utilization of health services; • Modify the beneficiary's improper utilization of Medicaid services through educational contacts and monitoring; • Prevent fragmentation of services and improve the continuity of care and coordination of services; and • Assure that beneficiaries are receiving health care services which are medically necessary and supported by evidence-based practices, thereby curtailing unnecessary costs to the program.

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				To accomplish these program objectives, the BMP performs the following functions: • Identifies beneficiaries who appear to be over-utilizing and/or misusing covered services. • Evaluates utilization of covered services to determine whether the services are appropriate to a beneficiary's medical condition(s). • Educates beneficiaries regarding appropriate utilization. • Monitors utilization patterns and institutes interventions to optimize program effectiveness. The beneficiary may be subject to utilization control mechanisms if it is determined that the beneficiary is overusing and/or abusing Medicaid services. When a beneficiary is enrolled in the BMP, they will remain in the program even as they may move between enrollment in fee-for-service (FFS) and Medicaid Health Plan (MHP) settings. Responsibility for administration of the BMP functions transfers between FFS and MHP settings when a beneficiary's enrollment status changes. In this chapter, references to responsibilities or actions of the Department mean the Medicaid FFS program or MHP under which the beneficiary is enrolled. A beneficiary who is enrolled in the BMP will be identified with the Benefit Plan ID of BMP. BMP will be indicated on the CHAMPS Eligibility Inquiry response as additional information.
			8.1 Definitions	The following definitions pertain to terminology used specific to the Beneficiary Monitoring Program and should not be used for interpretation of material found elsewhere in the Medicaid Provider Manual.

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				Beneficiary: An individual eligible to receive medical assistance through the Michigan Department of Community Health (MDCH). **Beneficiary Monitoring Program (BMP)**: A program to control utilization in which a beneficiary who has been found to engage in misutilization is placed to allow the Department to monitor and assure the medical necessity of services for that beneficiary. **BMP Authorized Provider**: A provider who has been approved to render services to a beneficiary enrolled in the Beneficiary Monitoring Program by MDCH or MHP BMP staff. Active BMP Authorized Providers are contained in the CHAMPS Eligibility Inquiry response as additional information. **Emergency Medical Condition**: Federal Medicaid regulations define an emergency medical condition (including emergency labor and delivery) as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to: • Place the person's health in serious jeopardy; or • Cause serious impairment to bodily functions; or • Cause serious dysfunction of any bodily organ or part. **Medicaid Health Plan (MHP)**: The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries.

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				Medical Assistance Program — The Department's program to provide for medical assistance established by Section 105 of Act No. 280 of the Public Acts of 1939, as amended, being S400.105 of the Michigan Compiled Laws, and Title XIX of the federal Social Security Act, 42 U.S.C. S1396 et seq. **Misutilization** — The use of medical assistance in excess of, or inappropriate to, the particular medical needs of the beneficiary as determined by the Department through investigation and analysis. Initial indicators of possible misutilization in light of a beneficiary's medical condition shall include, but are not limited to, unusually frequent physician, pharmacy or emergency department visits, frequent use of ambulance and/or non-emergency medical transportation services, and unusually frequent acquisition of drugs subject to abuse. **Negative Action** — Action by the Department (or MHP) to discontinue, terminate, suspend, or reduce public assistance or services. **Provider** — An individual, firm, corporation, association, agency, institution, or other legal entity which has been approved to provide medical assistance to a beneficiary pursuant to the Medical Assistance Program. **The Department** — The Michigan Department of Community Health (MDCH).
			8.2 BMP Enrollment Criteria	The criteria in the following subsections are used to identify beneficiaries to be placed in the BMP. Enrollment in the BMP is determined after review of the beneficiary's usage of medical services. Beneficiaries may be enrolled in BMP when any of the following criteria (alone or in combination) are present.

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			8.2.A. Fraud	The beneficiary is suspected, or has been convicted, of fraud for one or more of the following: • Selling or purchasing products/pharmaceuticals obtained through Medicaid. • Altering prescriptions to obtain medical services, products or pharmaceuticals. • Stealing prescriptions/pads; provider impersonation. • Using another individual's identity, or allowing another individual to use their identity, to obtain medical services, products or pharmaceuticals.
			8.2.B. Misutilization of Emergency Department Services	Criteria include, but are not limited to, the following: • More than three emergency department visits in one quarter. • Repeated emergency department visits with no follow-up with a primary care provider (PCP) or specialist when appropriate. • More than one outpatient hospital emergency department facility visit in one quarter. • Repeated emergency department visits for non-emergent conditions.
			8.2.C. Misutilization of Medical Transportation Services	Criteria include, but are not limited to, the following: • Use of emergency medical transportation services for circumstances that do not qualify as an emergency medical condition.
			8.2.D. Misutilization of Pharmacy Services	Criteria include, but are not limited to, the following: • Utilizing more than three different pharmacies in one quarter. • Aberrant utilization patterns for drug categories listed in the Drug Categories subsection of this chapter over a one-year period. • Obtaining more than five prescriptions for drug categories listed in the Drug Categories subsection of this chapter in one quarter (including emergency prescriptions).

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			8.2.E. Misutilization of Physician Services	Criteria include, but are not limited to, the following: • Utilizing more than one physician/physician extender in different practices to obtain duplicate or similar services for the same or similar health condition and/or to obtain prescriptions for the drug categories listed in the Drug Categories subsection of this chapter in one quarter. • Utilizing covered services to obtain prescriptions for drugs subject to abuse and paying cash to obtain the drugs.
			8.2.F. Other	MDCH will review additional criteria as misutilization patterns emerge or are identified by the Department.
			8.3 Drug Categories	MDCH considers the following drug categories as having high potential for abuse: • Narcotic Analgesics • Barbiturates • Sedative-Hypnotic, Non-Barbiturates • Central Nervous System Stimulants/Anti-Narcoleptics • Anti-Anxieties • Amphetamines • Skeletal Muscle Relaxants
			8.4 Notification and Enrollment	Notification of enrollment in the BMP is sent to the beneficiary to the address on file with the Department of Human Services (DHS). It is the beneficiary's responsibility to report a change of address to DHS. This notification includes the following: • Information regarding the utilization patterns and concerns; • The enrollment effective date; and • Instructions on the selection of providers (which must be approved by the Department).

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				The beneficiary is given 10 calendar days to contact the Department and discuss the findings prior to the enrollment effective date. Enrollment of a beneficiary in a MHP may be determined by the Department or the MHP using approved criteria. Enrollment in the BMP does not constitute a negative action by the Department or the MHP. Enrollment of a beneficiary in the BMP does not suspend, reduce, discontinue, or terminate any services or assistance that a beneficiary is eligible for at the time of the beneficiary's enrollment in the BMP.
			8.5 Beneficiary Monitoring Program Control Mechanisms	See subsection information below.
			8.5.A. Obtaining Drugs Subject to Abuse	Michigan's Pharmacy Benefits Manager (PBM) processes all point of sale (POS) prescription drug claims for MDCH. Requests for prescriptions (including emergency prescriptions for the therapeutic drug categories listed above) are evaluated against other prescriptions filled for the beneficiary and paid by Medicaid in the last 34 days. Beneficiaries in the BMP are prevented from filling or refilling prescribed medications listed in the Drug Categories subsection of this chapter until 95 percent of the medication quantity limits would have been consumed in compliance with the prescribed dose, amount, frequency and time intervals as ordered by the prescribing provider, and consistent with Medicaid limits. Additional controls on drugs subject to abuse may be imposed. MDCH may restrict access to these drug classes through pharmacy and/or prescribing provider assignment. Providers authorized to fill/prescribe drugs subject to abuse are identified by a "Y" indicator in the "Send to PBM" field of the CHAMPS Eligibility Inquiry response, BMP Restrictions page. Additional information regarding provider assignments is contained in the following subsection. Drugs subject to abuse ordered in conjunction with exempt services, to include emergency (72 hour) medication supplies, may require communication with the MDCH PBM and/or BMP program staff. (Refer to the Directory Appendix for contact information.) Refer to the Exempt Services subsection for additional information.

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			8.5.B Assigned Providers	The BMP may assign beneficiaries to specific providers through whom covered services can be obtained. BMP Authorized Providers that may be assigned include, but are not limited to, any one or more of the following: • Specific primary care provider (PCP) • Specific pharmacy • Specific outpatient hospital • Specific specialist provider • Specific group practice
			8.5.C. Restricting Benefits	In some cases, the Department may find that a restriction of optional benefits (i.e., pharmacy) is an appropriate intervention. In the event of continued misutilization, as defined in the Definitions subsection and as outlined in the BMP Enrollment Criteria subsection (and its subsections), optional benefits may be reduced in accordance with federal and state regulations. Beneficiaries subject to a benefit restriction will receive written notice of the action, the effective and end dates applicable, and appeal information.
			8.5.D. Exempt Services	The following services are exempt from the BMP: • Emergency services • Dental services • Services rendered by a nursing facility provider • Services rendered in an inpatient hospital • Hospice services • Optometry services Although these services are exempt, controls on drugs subject to abuse are maintained in MDCH information systems and will impact the beneficiary's ability to obtain certain pharmaceutical services using Medicaid benefits. Refer to the Obtaining Drugs Subject to Abuse subsection for additional information.

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			8.6 Monitoring and Review	Beneficiaries are placed in the BMP for a minimum of 24 months. The utilization of medical services and drugs is routinely monitored and the effectiveness of the BMP interventions is evaluated. The Department shall review the placement at least once every 24 months.
			8.7 Provider Responsibilities	See subsection information below.
			8.7.A. All Providers	Eligibility must be verified before providing service. BMP enrollees are indicated on the CHAMPS Eligibility Inquiry response as additional information. If the BMP Provider Restriction Indicator is "Y", the hyperlink will be activated. The hyperlink will open the BMP Restrictions page which contains BMP Authorized Provider information. If there is no provider listed, the beneficiary is restricted only by the pharmaceutical refill tolerance for that date of service. CHAMPS BMP Authorized Provider information is only available for beneficiaries enrolled in FFS and for beneficiaries enrolled in a MHP receiving services carved out of the MHP benefit. For services provided by a MHP to a beneficiary enrolled in BMP, authorized provider information must be obtained from the MHP. FFS reimbursement for BMP enrollees is limited to exempt services, services provided by an active BMP Authorized Provider per the beneficiary's eligibility file, and services provided by a referred provider when all of the following are present: • The beneficiary was referred by an active BMP Authorized Provider; and • The referred provider has a current Beneficiary Monitoring Primary Provider Referral Notification/Request (form MSA-1302) from the BMP Authorized Provider. Rendering (and referring when applicable) provider NPI numbers are required on claim submissions.

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			8.7.B. BMP Authorized Providers	The BMP assigns the PCP. The beneficiary's assigned PCP will receive a monthly case management fee (applies to FFS beneficiaries only). It is the responsibility of the PCP to supervise the case management and coordination of all prescribed drugs, specialty care, and ancillary services. Reimbursement for any ambulatory service will not be made unless the service was provided, referred, prescribed, or ordered by the PCP and the claim includes the appropriate information. The beneficiary may participate in the PCP and other provider assignment processes, both initially and through request for changes to established BMP Authorized Providers. If the Department has reason to suspect that a beneficiary's provider selection will not contribute to a reduction in utilization and/or be appropriate to the beneficiary's health condition(s), the selection may be denied. If the beneficiary fails to respond to the Department with provider selections, the Department may assign providers without beneficiary participation. Written notice of provider assignments will be mailed to the beneficiary and the provider. When applicable (e.g., Department assigned providers, denial of request to change providers), appeal information and instructions will accompany written notice.
			8.7.C. Referrals for BMP Enrollees	The BMP Authorized PCP must complete a MSA-1302 when referring a BMP enrollee for other specialty services. This form applies to beneficiaries with Medicaid FFS program eligibility. (Refer to the Forms Appendix for a copy of the form and form completion instructions.)
			8.7.D. Discharge from Practice	It is the responsibility of the BMP Authorized Provider to notify the Department when a BMP enrollee is discharged from their practice. General practice standards should be followed with regard to patient notification. Written communication informing the beneficiary of the intent to sever the relationship and/or the MSA-1302 indicating "discharge from practice" may be sent to the Department to satisfy this responsibility.
			8.7.E. Potential Misutilization	To report potential misutilization of services, contact the MDCH Beneficiary Monitoring Program. (Refer to the Directory Appendix for contact information.)

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			8.7.F. Fraud	Suspected beneficiary fraud should be referred to the Department of Human Services, Office of Inspector General (DHS-OIG). (Refer to the Directory Appendix for contact information.)
			8.8 Changes in Enrollment	A beneficiary enrolled in the BMP will remain in the BMP for the minimum time period regardless of any change in enrollment status (e.g., change from fee-for-service to managed care, break in eligibility, incarceration, etc.). When a beneficiary in the BMP has a change in enrollment, responsibility for monitoring the beneficiary moves from the Department to the MHP or vice versa.
			8.9 Termination of BMP	When the beneficiary's utilization has been determined to be at an appropriate level or there is a change in medical status, the Department may terminate the beneficiary's enrollment in BMP.
			8.10 Appeals	Any written notice of a negative action shall include reference to the beneficiary's right to appeal. The appeal process shall conform to Michigan Administrative Code (MAC) Rules R400.901 to R400.922, except that action related to beneficiary placement in the BMP to control utilization shall not be considered a suspension, reduction, discontinuance, or termination of medical assistance under subrule 1 of R 400.903 and subrule 5 of R 400.904. The MHP is the respondent in BMP-related hearings pertaining to actions taken by the MHP for its members.
		Pharmacy	14.10 Narcotic Analgesics	The 1st paragraph was revised to read: ."..whether the drug is prescribed by the same or different healthcare provider or for a different drug in the same class, until 90 percent (95 percent for Beneficiary Monitoring Program beneficiaries) of the drug quantity limit has been consumed in compliance with ...

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				The 2nd paragraph was revised to read: Hospice (Benefit Plan ID of Hospice) beneficiaries are exempt from refill tolerance restriction. Beneficiary Monitoring Program beneficiaries are also exempt from refill tolerance restriction.
		Pharmacy	Section 18 – Beneficiary Monitoring Program	The 1st sentence was revised to read: The purpose of the Beneficiary Monitoring Program (BMP) is to monitor and control inappropriate utilization of covered services, including prescribed drugs.
		Directory Appendix	Reporting Fraud, Abuse, or Misuse of Services	Addition of information: Contact/Topic: Beneficiary Monitoring Program (BMP) Phone #: 800-622-0276 Mailing Address: MDCH Program Review Division Beneficiary Monitoring Program P.O. Box 30170 Lansing, MI 48909-7979 Information Available/Purpose: Report potential misutilization of services by Medicaid beneficiaries.
		Forms Appendix	MSA-1302; Beneficiary Monitoring Primary Provider Referral Notification/ Request	Form was revised to incorporate changes.

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MSA 13-06	3/1/2013	Practitioner	3.9 Children in Foster Care (new subsection; existing subsection re-numbered)	Medical interventions, screenings, and various preventive health care services are required to be up-to-date for all children in foster care under 21 years of age. The care of children/youth should be comprehensive, well-coordinated, and fully documented throughout their stay in foster care. All children in foster care under 21 years of age must receive a full medical examination by a primary care provider (PCP) within the first 30 days after entering foster care. When scheduling the appointment, the foster care parent will identify him/herself as the foster care parent and will inform the PCP that the child recently entered the foster care system and needs to be seen for a full health maintenance visit (EPSDT/preventive Well Child visit). The PCP's office staff should obtain from the foster care parent the completed Department of Human Services (DHS) form "Consent to Routine, Non-surgical Medical Care and Emergency Medical or Surgical Treatment", or consent from the child in foster care if the child is at least 18 years of age, before the child in foster care is seen by the PCP. This form provides the PCP with informed consent and the child's DHS foster care worker's contact information. (DHS forms are available on the DHS website. Refer to the Directory Appendix for website information.) The PCP must complete the health maintenance visit regardless of whether or not the child in foster care recently received a health maintenance visit prior to entry into the foster care system. The medical evaluation must follow the American Academy of Pediatrics (AAP) Bright Futures guidelines and Medicaid EPSDT policy. The examination should be completed according to the recommendations for the nearest or most appropriate periodic examination age. The PCP will assess the child in foster care for medical, dental, developmental, and mental health needs. The full medical evaluation will include an immunization review, health history, and physical examination as indicated by the Bright Futures Recommendations for Preventive Pediatric Health Care Periodicity Schedule. The periodicity schedule is available on the American Academy of Pediatrics (AAP) website. (Refer to the Directory Appendix for website information.) The medical examination should be documented on the age-appropriate DHS Well Child Exam form. DHS forms are available on the DHS website. (Refer to the Directory Appendix for website information.) Providers may use their own Well Child Exam form if the form contains all of the elements of the DHS form.

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				All children in foster care who are three years of age or older at the time of entry into foster care will receive a dental examination within 90 days of entry into foster care unless the child had a dental examination in the six months prior to foster care placement. It is the responsibility of the foster care parent to take the child to the dentist. A psychosocial/behavioral assessment must be completed at each scheduled EPSDT/preventive Well-Child visit. For children in foster care, a validated and normed screening instrument must be used. The PCP is responsible for scoring and interpreting the results of the screening instrument and proposing recommendations regarding follow-up. The PCP will recommend to the DHS foster care worker, the birth parents, and the foster care parents (when applicable) when the child in foster care may benefit by visiting with a mental health professional. Recommended screening instruments include the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) and the Pediatric Symptom Checklist (PSC). (Refer to the Directory Appendix for ordering information.) The screening instrument (i.e., questionnaire) will be completed by a person who knows the child best (preferably for at least 30 days) before the child in foster care is to be seen by the PCP. This may be the child's birth parent, foster care parent, caregiver, or other adult who knows the child. The DHS foster care worker will be responsible for identifying the individual who is to complete the questionnaire. The child in foster care will be referred for a prompt follow-up assessment by an appropriate medical, dental, developmental, or mental health professional for any further identified health needs.

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			3.9.A. Psychotropic Medication Treatment	A psychiatric diagnosis using the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders must be made before prescribing psychotropic medication to any child in foster care. When the PCP determines that the child in foster care requires psychotropic medication treatment, the prescribing PCP must obtain a written and signed informed consent from either the child's birth parent (when the child is a temporary court ward), the child (if the child is at least 18 years of age), or other legal guardian (for state or permanent court wards) before treatment with any psychotropic medication begins. Other legal guardians for state or permanent court wards may be the DHS foster care worker for children/youth in guardianship of Michigan Children's Institute (MCI), or the court of jurisdiction for children/youth in guardianship of the county. Foster care parents cannot consent to administration of psychotropic medication. For questions regarding who may provide consent for treatment with psychotropic medications, the PCP may contact the child's DHS foster care worker. The DHS foster care worker's contact information may be obtained from the DHS form "Consent to Routine, Non-surgical Medical Care and Emergency Medical or Surgical Treatment." Informed consent must be documented by completing the DHS "Psychotropic Medication Informed Consent" form (DHS-1643). (DHS forms are available on the DHS website. Refer to the Directory Appendix for website information.) Informed consent includes an explanation from the prescribing PCP regarding the child's diagnosis, proposed treatment, expected outcomes, any side effects, risks involved, discussion of laboratory findings and ongoing monitoring, uncommon but potentially severe adverse events, a discussion of alternative treatments, the risks associated with no treatment,

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				and the overall potential benefit-to-risk ratio of treatment. If consent is denied by the child's birth parent or other legal guardian, or the consent cannot be obtained and all parties involved agree the medication is needed, a court order shall be obtained by the DHS foster care worker to authorize the administration of the psychotropic medication to the child in foster care held in legal custody. If a child is prescribed psychotropic medication prior to enrollment in the foster care system, the DHS-1643 must be completed within 45 days of a child's entry into the foster care system to assure uninterrupted psychotropic medication treatment. The child in foster care who has reached 18 years of age is able to consent to and/or refuse medical treatment. A new informed consent form is required if there is a change in provider, a change in medication, or if the child has reached 18 years of age. Informed consent forms must be renewed annually.
			3.9.B. Enrollment and Billing	PCPs may complete and bill for an EPSDT/preventive Well Child visit for any child who must be seen within 30 days of entering the foster care system, and for any additional follow-up visits the PCP believes are necessary. The PCP will be reimbursed even if the child in foster care recently received a preventive health service prior to entry into the foster care system. The PCP may bill for up to three screenings provided during a visit using the appropriate developmental screening codes for scoring and interpreting developmental, autism, and behavioral health screens for a child in foster care under 21 years of age.
		Acronym Appendix		addition of: MCI – Michigan Children's Institute PSC – Pediatric Symptom Checklist
		Directory Appendix	Provider Resources	Under "American Academy of Pediatrics (AAP) Bright Futures Practice Guides": • the website address was revised to read ".. Materials >> Practice Guides on Oral Health, Mental Health, and Physical Activity" • "Information Available/Purpose" was revised to read "Practice guides on oral health, mental health, and physical activity"

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		Directory Appendix	Other Health Care Resources/Programs	addition of: Contact/Topic: Children in Foster Care Web Address: 1. www.michigan.gov/dhs-contracts >> Foster Care Forms 2. http://www.brightfutures.org/mentalhealth/pdf/tools.html >> Pediatric Symptom Checklist 3. http://www.massgeneral.org/psychiatry/services/psc_forms.aspx 4. http://agesandstages.com Information Available/Purpose: 1. Department of Human Services (DHS) Well Child Exam forms 2. Pediatric Symptom Checklist 3. Pediatric Symptom Checklist in other languages 4. Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)
MSA 13-05	3/1/2013	General Information for Providers	1.3 ListServ Communications (new subsection; following subsections re-numbered)	Subsection text reads: The MDCH Medical Services Administration (MSA) offers individuals the option of receiving automated announcements regarding the Michigan Medicaid Program (i.e., changes to policy, billing issues, training opportunities, etc.) through subscription to an e-mail listserv. Subscription instructions are posted on the MDCH website. (Refer to the Directory Appendix for website information.)
		Directory Appendix	Policy/Forms/Publications	Addition of: Contact/Topic: ListServ Communications Web Address: www.michigan.gov/medicaidproviders >> Click "Listserv Instructions" under Hot Topics Information Available/Purpose: Subscription instructions

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MSA 13-04	3/1/2013	Vision	3.6 Contact Lenses	Subsection text was revised as stated in the following subsections.
			3.6.A. Evaluation	Subsection text reads: A comprehensive contact lens evaluation is a Medicaid benefit when the beneficiary presents with one of the following conditions (use appropriate HCPCS comprehensive contact lens evaluation code): • Aniridia • Anisometropia or Antimetropia (of two diopters or greater that results in Aniseikonia) • Aphakia • Irregular cornea • Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses) • Other conditions which have no alternative treatment (e.g., Aniseikonia with documentation and severe Keratoconjunctivitis sicca)
			3.6.B. Prescription and Fitting	Subsection text reads: The prescription and fitting of contact lenses is a Medicaid benefit and requires PA, except for beneficiaries who are under six years of age with a diagnosis of aphakia.

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			3.6.B.1. Prescription	Subsection text reads: The prescription for contact lenses requires the complete description of contact lens specifications. The following must be included on a prescription for contact lenses: • complete description of the contact lens(es) parameters • material of the contact lens(es) • manufacturer of the contact lens(es) • material discard and replacement schedule • number of lenses required to provide a one-year supply • prescription expiration date
			3.6.B.2. Fitting	Subsection text reads: The fitting of the contact lens(es) must include: • determination of appropriate initial contact lens parameters based on clinical observation, and measurements of the eye with and/or without a trial (sample) contact lens. • a trial or adaption period of one to three months, including a fitting warranty that provides for adjustments in the contact lens parameters either by exchange or by modification of existing materials. **Note:** Certain custom contact lens designs may not be warranted by the manufacturer. This type of custom contact lens design will be considered on a case-by-case basis. The provider must provide a detailed explanation of need, initial cost, and potential re-fitting cost. • instruction of proper insertion, removal, disinfection, and care of the contact lens(es). • initial supply of contact lenses, storage case, and solutions sufficient to last until the fitting is complete.

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			3.6.C. Replacement and Supplies	Subsection text reads: Procurement of contact lenses is to be done through the vision provider's own source. The Documentation of Medical Necessity for the Provision of Contact Lenses form (MSA-0892) outlines the information required when requesting contact lens PA. A sample of this form is provided in the Forms Appendix and can also be obtained through the MDCH website. (Refer to the Directory Appendix for website information.) This form must be attached to the Vision Services Approval/Order form (DCH-0893) and submitted to MDCH as part of the PA process. (Refer to the Prior Authorization subsection in this chapter for additional information.) One contact lens replacement in a year for each eye is allowed for beneficiaries age 21 and over. Two replacements in a year are allowed for each eye for beneficiaries under age 21. (One year is defined as 365 days from the date the first pair of contact lenses [initial or subsequent] was ordered.) Except as previously indicated, contact lens supplies (e.g., wetting and cleaning solutions, carrying cases) are not Medicaid benefits.
		Forms Appendix	MSA-0892 Documentation of Medical Necessity for the Provision of Contact Lenses	Form was updated to incorporate changes.
MSA 13-03	2/15/2013	Adult Benefits Waiver		Textbox on Table of Contents page regarding open enrollment was removed.

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MSA 12-69	12/28/2012	Hospital	4.2 Utilization Review 4.3 Inpatient Hospital Post-Payment Reviews 4.3.A. Post-Payment Audits 4.3.B. Post-Discharge Utilization Review 4.4 Quality Review 4.5 Contractor Monitoring 4.6 Confidentiality 4.7 Planning for Discharge 4.9 Outpatient Hospital Post-Payment Review	Subsections were deleted. (NOTE: 4.8 Termination of Benefits was re-located to the General Information for Providers chapter as a "Technical Change.")
			4.2 Inpatient and Outpatient Post-Payment Reviews (new subsection)	Subsection text reads: MDCH and/or its audit contractor will perform automated reviews and medical record reviews on inpatient and outpatient services that have been paid. An automated review is a re-examination of a claim payment at the system level. These reviews will focus on errors in pricing, coverage, coding determinations and payment of duplicate claims. A medical record review is a more comprehensive comparison of a hospital's Medicaid claims against the hospital's medical records. The objective of the MDCH post-payment review process is to ensure that MDCH reimbursement is for medically necessary care provided in the appropriate setting, that diagnostic and procedural information is valid, and that the care rendered meets current clinical and quality standards of practice. Cases are reviewed using Medicaid-approved Severity of Illness/Intensity of Services (SI/IS) criteria, clinical judgment and generic quality screens.

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				All reviews include consideration of medical necessity, appropriateness of setting, coding validity/accuracy, and the quality and intensity of care provided to the beneficiary. The audit will also ensure that the quality and intensity of hospital services conform to current and acceptable standards of medical practice and Medicaid policies, procedures, and coding guidelines.
			4.3 Confidentiality (new subsection)	Subsection text reads: As an agent of the State, the MDCH audit contractor may access all records related to care provided to Medicaid beneficiaries and is subject to the same state and federal confidentiality requirements as Medicaid staff. The failure of a hospital to make all records available to the contractor will result in denial of that case and subjects that hospital to Medicaid participation sanctions.

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