MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: All Provider 04-17

Issued: December 2004

Subject: Updates to the Medicaid Provider Manual

Effective: January 1, 2005

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

The Michigan Department of Community Health (MDCH) has completed the January 2005 update of the Michigan Medicaid Provider Manual. A copy of the updated manual will be distributed to all enrolled providers or provider groups via compact disc (CD) in January. A copy will also be available on the MDCH website by January 1st.

The January 2005 version of the manual does not highlight changes made since the January 2004 version. However, consistent with previous quarterly manual updates, tables attached to this bulletin describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change. (Some minor corrections [e.g., misspelled words], added references [e.g., directing reader to the website], and reorganizing of existing information, may not appear in the listed changes.) Subsequent changes made for the April, July, and October 2005 versions of the manual will be highlighted within the text of the on-line manual.

Manual Maintenance

This bulletin may be discarded when you begin using the January 2005 version of the Medicaid Provider Manual.

Questions

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

Approved

Paul Reinhart, Director
Medical Services Administration

Michigan Department of Community Health

Medicaid Provider Manual
January 2005 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
All		References to the Family Independence Agency were changed to Department of Human Services to reflect the recent name change of that department.	Update.
All		References to the Adult Benefits Waiver I (ABW I) were changed to Adult Benefits Waiver (ABW).	Update.
General Information for Providers	1.6 Provider Liaison Meetings (New Subsection Added)	This new subsection contains the following text: MDCH routinely schedules meetings to meet with provider specialty groups (e.g., physicians, hospitals, pharmacies, etc.) to discuss issues of interest/concern. The meetings are arranged through the various provider professional associations, though all affected providers and interested parties are welcome to attend. A calendar of provider liaison meetings is posted on the MDCH website, along with contact information. (Refer to the Directory Appendix for website and contact information.)	Additional information of interest to providers.
Billing & Reimbursement for Dental Providers	All	References to the Dental Procedure Codes Appendix were changed to refer to the Dental Procedure Code Database available on the MDCH website at www.michigan.gov/mdch >>Providers >>Information for Medicaid Providers >>Provider Specific Information.	Information moved to the MDCH website.
Billing & Reimbursement for Institutional Providers	Section 1 – General Information	"Outpatient Therapy Providers" was added to the list of providers.	Update.
Billing & Reimbursement for Institutional Providers	3.2 Void/Cancel a Prior Claim	Reference to Form Locator 47 was deleted.	Update.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	5.13 Transplants	The following bullet was added: • Organ acquisition costs are reimbursed at 100% of charges when billed using either Revenue Code 811 or 812. This applies to heart, kidney, liver, lung, simultaneous pancreas/kidney, or pancreas transplants. This does not apply to bone marrow transplants. All bone marrow transplant charges are reimbursed at the hospital's cost to charge ratio.	Updated to reflect current reimbursement policy.
Billing & Reimbursement for Institutional Providers	6.36 Therapies	The following codes were added to the list of dual-use CPT codes: 92610, 97018, 97022, 97032, 97035, 97504, 97525, 97542 The seventh bullet was deleted from the Speech-Language Therapy portion of the table.	Update.
Billing & Reimbursement for Institutional Providers	7.1 Revenue and CPT/HCPCS Codes	The following revenue codes were added to the list of revenue codes requiring CPT/HCPCS code on the claim line: 0343 – Diagnostic Radiopharmaceuticals 0344 – Therapeutic Radiopharmaceuticals	Update.
Billing & Reimbursement for Institutional Providers	7.2 Minor Surgery/ Procedure Codes	This subsection was deleted from the chapter. The information is now available on the MDCH website at www.michigan.gov/mdch >> Providers >>Information for Medicaid Providers >>Provider Specific Information >>Outpatient Hospital Subsequent subsections were renumbered.	Information moved to the MDCH website for ease of updating.
Billing & Reimbursement for Institutional Providers	7.3 Interventional Radiology Services	This subsection was deleted from the chapter. The information is now available on the MDCH website at www.michigan.gov/mdch >> Providers >>Information for Medicaid Providers >>Provider Specific Information >>Outpatient Hospital Subsequent subsections were renumbered.	Information moved to the MDCH website for ease of updating.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	8.1.E. Billed Facility Days	The Day of Discharge portion of the table was changed to read: Medicaid does not reimburse the day of discharge unless the discharge is due to the resident's death. When billing, the facility must indicate 20 (expired) as the Patient Status Code. A discharge due to death is counted in the facility census. One-Day Stay was added to the table with the following text: A nursing facility is reimbursed for a one-day stay if a Medicaid beneficiary is admitted to the facility and, the same day, is discharged from the facility due to death, return home, or transfer to another institution that is not a Medicaid-enrolled provider. The one-day stay does not apply to a beneficiary admitted to a nursing facility if, later that day, the beneficiary is discharged and transferred to another nursing facility or an inpatient hospital and, at midnight, the second facility or hospital claims the beneficiary in its daily census.	Changed for clarification.
Billing & Reimbursement for Institutional Providers	8.10 Ancillary Physical and Occupational Therapy, Speech Pathology (Renumbered)	Procedure code 97504 was added to the list of codes in the Occupational Therapy portion of the table.	Correction.
Billing & Reimbursement for Institutional Providers	8.13 Other Service Revenue Codes	The following was added to the end of the first bullet: Services for nursing facility beneficiaries requiring outpatient physical therapy, outpatient speech pathology, and outpatient occupational therapy must be provided and billed under Medicare Part B where applicable, even if no payments are made under Medicare Part A for the nursing facility stay.	Inadvertently omitted when bulletin Nursing Facilities 04-04 was incorporated into the manual.
Adult Benefits Waiver	Section 2 – Coverage and Limitations	The Substance Abuse portion of the coverage chart was changed to reflect these services are provided by the Substance Abuse Coordinating Agencies (CAs).	Correction.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Children's Special Health Care Services	Section 3 – Medical Eligibility	The second sentence in the paragraph immediately following the list of covered medical diagnostic categories was changed to read: CSHCS also does not cover mental health care, primary care, **well child visits, or immunizations**.	Added for clarification.
Children's Special Health Care Services	8.3 Partial Month Coverage	The subsection was changed to read: If a client enters or leaves a facility that is not a covered facility (e.g., nursing home or intermediate care facility) during a month of eligibility, the client remains a CSHCS client for the remainder of that month. However, services provided to the client while in the facility are not covered (i.e., reimbursable) by CSHCS, as these facilities are responsible for providing the medical care. (Refer to the General Information Chapter in this manual for additional information for clients who also have Medicaid coverage.)	Modified for clarification/ consistency.
Chiropractor	1.2 Beneficiary Co-Payment	The third paragraph was revised to read: Providers may not refuse to render service if a beneficiary is unable to pay the co-payment amount at the time the service is provided. However, the uncollected co-payment is considered a bad debt which allows the provider to refuse to provide future services according to Michigan's State Plan. Providers who elect not to provide services based on a history of bad debt, including unpaid co-payments, must give beneficiaries appropriate verbal notice and a reasonable opportunity for payment.	Clarification
Dental	All	The Dental Procedure Codes Appendix was removed from the chapter. All references to the Appendix were changed to refer to the Dental Procedure Code Database available on the MDCH website.	Information moved to the MDCH website for ease of updating.
Dental	2.5 Loss or Change in Eligibility	References to dentures were modified to indicate complete and partial dentures. The following bullet was added: • This does not apply to immediate dentures.	Added for clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	Section 3 – Co-Payments	The following bullet was added: • Beneficiaries cannot be charged a co-payment for infection control, sterilization or for other routine procedures that are considered part of normal office operations. The paragraph immediately following the bullets was changed to read: Providers may not refuse to render service if a beneficiary is unable to pay the co-payment amount at the time the service is provided. However, the uncollected co-payment is considered a bad debt which allows the provider to refuse to provide future services according to Michigan's State Plan. Providers who elect not to provide services based on a history of bad debt, including unpaid co-payments, must give beneficiaries appropriate verbal notice and a reasonable opportunity for payment.	Clarification.
Dental	4.1.A. Provision of Care in the Inpatient or Outpatient Setting	The subsection was changed to read as follows: Admission to an inpatient or outpatient hospital setting for any **nonemergency dental service** is covered **only** for beneficiaries under the age of 21 for the following conditions: • The patient has a concurrent hazardous medical condition; • The nature of the procedure requires it to be performed in a hospital setting; or • Other contributing factors, such as age, behavioral problems due to mental impairment, etc., necessitate hospitalization. Coverage of dental services for beneficiaries age 21 and older is limited to emergency services only when performed in the hospital setting for the relief of pain and/or infection. The dentist/physician must document in the beneficiary's medical record the condition that required the dental service to be done in the hospital setting. Hospitalization is not a benefit for the convenience of the dentist or beneficiary or because of apprehension on the part of the beneficiary.	Added for clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.1.A. Clinical Oral Evaluations (Examinations)	The third sentence was changed to read: Typically, it should include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, periodontal conditions, **occlusal relationships**, hard and soft tissue anomalies, oral cancer screening, prosthesis condition and usage, etc.	Added for clarification.
Dental	6.1.B. Comprehensive Oral Evaluation	The following sentence was added at the end of the paragraph: In addition, a complete treatment plan must be included that addresses the beneficiary's needs.	Added for clarification.
Dental	6.1.C. Periodic Oral Evaluation	The following sentence was added at the end of the paragraph: In addition, a complete treatment plan must be included that addresses the beneficiary's needs.	Added for clarification.
Dental	6.1.D. Limited Oral Evaluation – Problem Focused	The following sentence was added at the end of the first paragraph: In addition, the findings, diagnosis, and treatment plan for the diagnosis must be included in the beneficiary's chart. The second paragraph was changed to read: A limited oral evaluation can be billed in conjunction with radiographs **and/or extractions (simple or surgical)** and considered a covered benefit.	Added for clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.1.E. Consultation	The first two sentences were changed to read: A consultation provided by **another** dentist or a physician (MD, DO) is a benefit for beneficiaries under age 21. Medicaid defines a consultation as a service rendered by a physician**/dental specialist** whose opinion or advice is formally requested by another appropriate practitioner (e.g., physician, certified nurse-midwife [CNM], dentist) for the further evaluation and/or management of the beneficiary. The following sentence was added to the second paragraph: The dentist requesting the consultation cannot bill the consultation procedure code.	Added for clarification.
Dental	6.1.F. Radiographs	The first sentence was changed to read: Radiographs are benefits for all beneficiaries and are limited to that number **medically** necessary to make a diagnosis (other limitations apply to radiographs—see below).	Added for clarification.
Dental	6.1.F.9. Occlusal Film (new subsection)	This new subsection contains the following: An occlusal radiograph is a covered benefit for beneficiaries under age 21. Providers must use the occlusal film if billing the procedure. It is not the type of view that determines the procedure, it is the type of film used.	Added for clarification.
Dental	6.2.B. Topical Application of Fluoride	The last sentence was changed to read: The topical application of fluoride via tray application **or fluoride varnish** are the methods covered. The last bullet was changed to read: • Fluoride tablets or capsules prescribed by the dentist **(may be covered as a pharmacy benefit for beneficiaries under the age of 10).**	Added for clarification.
Dental	6.4.B. Pulpotomy	The following sentence was added: If exfoliation appears imminent, a pulpotomy is not a covered benefit.	Added for clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.7.A. Extractions	The following sentences were added: An extraction is not a covered benefit if exfoliation is imminent. Surgical extractions are not a covered benefit in cases of multiple extractions in the same quadrant. The following sentence was changed to read: A surgical extraction is a benefit only when the removal of bone **and the elevation of mucoperiosteal flap and/or sectioning of a tooth** is required to facilitate the extraction.	Added for clarification.
Family Planning	All	The Family Planning Procedure Code Appendix was removed from the chapter. All references to the Appendix were changed to refer readers to the Family Planning Database on the MDCH website at www.michigan.gov/mdch >>Providers >>Information for Medicaid Providers >>Provider Specific Information.	Updated information available on the MDCH website.
Federally Qualified Health Centers	Section 1 – General Information	The first and second sentences were changed to read: This chapter applies to Federally Qualified Health Centers (FQHCs), designated FQHC look-alikes, and Tribal Health Centers (THCs electing to be reimbursed as an FQHC). Subsequent references to FQHCs in this chapter are applicable to all three entities.	Added for clarification.
Federally Qualified Health Centers	1.5 Nonenrolled Provider Services	The fifth sentence was changed to read: The clinical psychologist and clinical social worker services must be billed with the appropriate procedure codes that reflect the services provided. The last paragraph was changed to read: Services provided by clinical psychologists and clinical social workers are included in the 20 outpatient visits for MHP members. FQHCs must participate as part of a MHP provider panel in order to bill for services provided to members, and all services must be prior authorized by the respective MHP.	Changed for clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Hearing Aid Dealer	1.6 Co-Payment	The paragraph immediately following the bullets was changed to read: Providers may not refuse to render service if a beneficiary is unable to pay the co-payment amount at the time the service is provided. However, the uncollected co-payment is considered a bad debt which allows the provider to refuse to provide future services according to Michigan's State Plan. Providers who elect not to provide services based on a history of bad debt, including unpaid co-payments, must give beneficiaries appropriate verbal notice and a reasonable opportunity for payment.	Clarification
Hospice	3.4.B. Nursing Facility	The following was added to the end of the sixth paragraph: The Medicaid reimbursement to the hospice for NF room and board is equal to 95% of the total Medicaid NF rate. For Class I NFs, reimbursement also includes 95% of the Quality Assurance Supplement (QAS) amount due the NF through the Quality Assurance Assessment Program (QAAP). QAAP funds are not included in the reimbursement for County Medical Care Facilities, Hospital Swing Beds, or specialized Medicaid Ventilator Dependent Care Units as they are not eligible for that program. Reimbursement for private hospital Long Term Care Units equals 95% of the Medicaid per diem plus the QAS. Public hospital LTCUs are not eligible for the QAS.	Added for clarification.
Hospital	5.6 Utilization Review	The third paragraph was changed to read: Post-discharge utilization review of medical/surgical and rehabilitation stays are conducted by the ACRC **as part of the audit process**.	Added for clarification.
Hospital	5.7 Post-Payment Review	The last sentence immediately preceding the table was changed to read: If a statistically-valid random sample, by hospital, determines that services billed lacked medical necessity/appropriateness, audit findings may be extrapolated to the entire Medicaid population receiving services in that facility **for the time period of the audit**, and are subject to recoupment and/or adjustment.	Added for clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
		The explanation in the table for DRG Validity was changed to read: The ACRC verifies the diagnosis and procedure codes on the hospital's claim on a post-payment basis for all claims paid on a DRG basis **as part of the audit process**. The explanation in the table for Medical Necessity/Appropriateness was changed to read: The ACRC also performs retrospective review for medical necessity of admissions, transfers and readmissions **as part of the audit process**.	
Hospital	Hospital Reimbursement Appendix 3.1 Medicare/Medicaid Claims	The third and fourth paragraphs were changed to read: For patients with Medicare Part B coverage and no Medicare Part A coverage, the Medicaid payment amount is determined by subtracting the Medicare Part B payment from the Medicaid inpatient amount that would otherwise be approved (either under DRG or per diem). For patients with Medicare Part A coverage, the Medicare payment and contractual adjustment is compared to the Medicaid inpatient amount that would otherwise be approved (either under DRG or per diem).	Revised for clarification.
Hospital	Hospital Reimbursement Appendix 11.5 Final Settlement	The following was added to the end of the first paragraph: . . . and sends the hospital a Medicaid audit adjustment report. Once this is done, the Medicare/Medicaid CMS 2552 report will not be amended.	Inadvertently omitted when bulletin MSA 03-05 was incorporated into manual.
Local Health Departments	2.1 Covered Services	A note was added to the chart of covered services to refer to the Dental Chapter of the manual for details regarding dental service coverage and limitations.	Added to avoid confusion.
Local Health Departments	3.2 MHP Encounters	The sentence immediately preceding the second set of bullets was changed to read: The following out-of-plan services do not require a contract **or prior authorization** between the LHD and the MHP:	Added for clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Local Health Departments	3.4 Other Insurance Encounters	The two paragraphs in this subsection were combined and changed to read: Medicaid services provided to FFS beneficiaries with other commercial health insurance carriers are eligible for full cost, and the encounters are considered Medicaid encounters. Medicaid requires beneficiaries' other insurance resources and their network providers to be utilized for all services covered under the private coverage before billing Medicaid. Even if the other insurance payment for a covered service exceeds the amount Medicaid would pay, providers must still bill the FFS procedure code and enter the other insurance payment on the claim. The claim showing other insurance reimbursement or zero payment must be processed through the FFS claim system in order to be counted as a Medicaid encounter. (Refer to the Billing & Reimbursement for Professionals and the Coordination of Benefits chapters of this manual for additional information.)	Changed for clarification.
Local Health Departments	4.1 Full Cost Methodology	The first paragraph was changed to read: The term full cost reimbursement as used in this chapter means the cost of providing Medicaid services, as determined by information provided on the Michigan Medicaid Cost Report for LHDs. Full cost is derived from reimbursement to the LHD from Medicaid FFS claims, MHPs, other third party insurers, quarterly payments, and initial and final settlements. A combination of local and state general funds provide the basis for full cost reimbursement and are used for claiming federal financial participation pursuant to 42 CFR § 433.51 and 42 CFR § 431.615. The last paragraph of the section was deleted.	Changed for clarification.
Mental Health/ Substance Abuse	1.5 Programs Requiring Special Approval	Drop-in Programs and Extended Observation Beds were added to the list of programs requiring special approval.	Update.
Mental Health/ Substance Abuse	2.3 Location of Service	The following sentence was added to the beginning of the last paragraph: Medicaid does not cover services delivered in Institutions of Mental Disease (IMDs) for individuals between ages 22 and 64, as specified in §1905(a)(B) of the Social Security Act.	Added for clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	14.3 Covered Waiver Services	The next to the last paragraph in the Environmental Accessibility Adaptations portion of the table was changed to read: If a family purchases a **home**, or builds a home **or addition** while the child is receiving waiver services, it is the family's responsibility to assure that the home will meet the child's basic needs, such as having a ground floor bath/bedroom if the child has mobility limitations. The CWP does not cover construction costs in a new home **or addition**, or a home purchased after the beneficiary is enrolled in the waiver. The CWP funds may be authorized to assist with the adaptation noted above (e.g., ramps, grab bars, widening doorways) for a home recently purchased.	Clarification.
Mental Health/ Substance Abuse	15.2.A. Supports Coordination Qualifications	The first bullet was changed to read: • A minimum of a Bachelor's degree in human services field **or a QMRP as defined in the Definition of Terms subsection.**	Update.
Mental Health/ Substance Abuse	17.3.K. Skill-Building Assistance	Reference to the Rehabilitation Act of 1973 was removed.	Update.
Mental Health/ Substance Abuse	17.3.M. Supported/ Integrated Employment Services	References to the Rehabilitation Act of 1973, as amended, and Michigan Rehabilitation Services were removed.	Update.
Mental Health/ Substance Abuse	17.3.N. Wraparound Services for Children and Adolescents (New subsection)	This new subsection contains the following text: Wraparound services for children and adolescents is a highly individualized planning process performed by specialized case managers who coordinate the planning for, and delivery of, wraparound services and incidental non-staff items that are medically necessary for the child beneficiary. The planning process identifies strengths, needs, strategies (staffed services and non-staff items) and outcomes. Wraparound utilizes a Child and Family Team with team members determined by the family, often representing multiple agencies, and informal supports. The Child and Family Team creates a highly individualized plan of service for the child beneficiary that consists of mental health specialty treatment, services and supports covered by the	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
		Medicaid mental health state plan, waiver, or B3 services. The plan may also consist of other non-mental health services that are secured from, and funded by, other agencies in the community. The wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child beneficiary and family, and is developed in partnership with other community agencies. This planning process tends to work more effectively with child beneficiaries who, due to safety and other risk factors, require services from multiple systems and informal supports. The Community Team that consists of parents, agency representatives, and other relevant community members oversees wraparound. Child beneficiaries served in wraparound shall meet two or more of the following: • Children who are involved in multiple systems. • Children who are at risk of out-of-home placements or are currently in out-of-home placement. • Children who have been served through other mental health services with minimal improvement • The risk factors exceed capacity for traditional community-based options. • Numerous providers are serving multiple children in a family and the outcomes are not being met. Wraparound planning and service coordination is reported with procedure code T1016; and items and services purchased with non-Medicaid funds are reported with procedure code H2022 in the encounter data system.	
Mental Health/ Substance Abuse	Children's Waiver Community Living Support Services Appendix 3.2 Decision Guide	The following was added after the fifth sentence: If the child is receiving Home Help services, those hours must be considered as part of the total hours allowable. For example, a child determined to have Category III level of care needs is eligible for a maximum of six hours a day while in school. If that child receives two hours per day of Home Help, CWP could then provide a maximum of four hours of CLS staffing per day.	Added for clarification.

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TECHNICAL CHANGES*

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<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td>Mental Health/ Substance Abuse</td><td>Children's Waiver Community Living Support Services Appendix 3.3 Decision Guide Table Definitions

(New subsection, subsequent subsections renumbered)</td><td>The definitions used in each section of the Decision Guide Table are as follows:
<table>
<tr><th>SECTION</th><th>DEFINITIONS</th></tr>
<tr><td>SECTION I – Number of Caregivers</td><td>Caregiver is defined as a legally responsible adult(s) living in the home or adult(s) who is not legally responsible but chooses to participate in providing care for the child.

Full-Time (F/T) is defined as a person who works 30 or more hours per week for wages or a person who attends school 30 or more hours per week.</td></tr>
<tr><td>SECTION II – Health Status of Caregivers</td><td>Significant health concerns of a caregiver is defined as one or more of the primary caregivers have a significant health or emotional condition which prevents that caregiver from providing care for the child. Example: A parent that recently had back surgery with full body cast or similar condition.

Some health concerns of a caregiver is defined as one or more primary caregivers (as defined above) have a health or emotional condition that interferes with, but does not prevent, provision of care. Examples: Alcoholism, depression, lupus, back pain when lifting, lifting restrictions and similar health concerns; or primary caregiver is in therapy three or more times per month.</td></tr>
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<tr><th>SECTION</th><th>DEFINITIONS</th></tr>
<tr><td>SECTION III - Additional Dependent Children</td><td>This section applies when the child has one or more siblings or related individuals under age 18, who reside in the home full-time and the caregiver is not paid for providing care.</td></tr>
<tr><td>SECTION IV - Additional Children With Special Needs</td><td>Additional special needs are identified when the child has one or more siblings or related individuals who reside in the home and do not currently receive hourly care supports.

Siblings with nursing needs are children who meet the criteria for Intensity of Care-High or Intensity of Care-Medium (refer to the Additional Mental Health Services (B3s) Section of this chapter), whether or not those children are developmentally disabled.

Siblings without skilled nursing needs are children with needs as identified in Category of Care I-IV definitions.</td></tr>
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CHAPTER	SECTION	CHANGE	COMMENT

SECTION	DEFINITIONS
SECTION V – Night Interventions	If the child requires one or two interventions at night and the time required to complete the interventions is one hour or less, Section V-1 applies. If the child requires an average of three or more interventions per night, or the time required to complete the interventions is more than one hour, Section V-2 applies.
SECTION VI – School	Average hours of school should be used to determine the appropriate range of hours. Include transportation time if provided by the school. The number of hours of school attendance is based on the school year that applies to the child's educational classification. Variations in hours may be seen for children without a summer program. This factor limits the maximum number of hours that can be authorized for a child of any age in a center-based school program for more than 25 hours per week, or a child who has reached the age of 6 and for whom there is no medical justification for a home-bound school program. The school maximum is also waived for that time period when a child is out of school for at least 5 consecutive days due to illness, surgery, or scheduled school breaks.

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CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	1.1 MDCH Pharmacy Benefits Manager and Other Vendor Contractors	The first paragraph after the bullets was changed to indicate beneficiaries may call the **PBM** Beneficiary Helpline.	Updated to reflect current process.
Pharmacy	1.2 Definitions	The term "Nursing Facility Pharmacy" was changed to "Long Term Care Pharmacy". The definition was not changed. The term "Bingo Cards" was added with the following definition: Bingo cards are cards, sheets, or blister packs of medications that are not separable into single tamper-evident unit packages and do not have each individual dose of the drug identified with the drug name, manufacturer, lot number, and expiration date of the drug, so that the drug can be legally used by the patient.	Changed to avoid confusion. Added for clarification.
Pharmacy	2.3 Sanctioned Prescribers	The first sentence was changed to read: MDCH does not reimburse for pharmaceuticals prescribed by providers sanctioned by the Federal Government, the State of Michigan, or for prescribers having a limited license or revoked license.	Update.
Pharmacy	13.6 Beneficiary Co-Payment	References to level of care 08, 55, and 56 were deleted. Reference to level of care 16 was added.	Changes made to avoid confusion.
Pharmacy	14.13 Unit	The term "Nursing Facility Pharmacy" was changed to "Long Term Care Pharmacy".	Changed to avoid confusion.
Pharmacy	15.1 Level of Care	References to level of care 55 and 56 were deleted.	Deleted to avoid confusion.
Pharmacy	15.2 Unit Dose Policy	The term "Nursing Facility Pharmacy" was changed to "Long Term Care Pharmacy".	Changed to avoid confusion.

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CHAPTER	SECTION	CHANGE	COMMENT
		The fourth bullet was changed to read: Bills for only beneficiaries with level of care (LOC) 02.	Added for clarification.
Pharmacy	Section - 19 Pharmacy Audit and Documentation	The wording of the Prescription Documentation portion of the table was changed to the following: Original written prescription and those created from phone, fax, or electronic transmissions must be created and maintained in written form. For originals and all refills, accurate prescription documentation must be readily accessible and maintained for six years. All of the following information for each prescription must be entered in the record: • prescription number • patient's name and address • prescriber's name • prescriber's federal DEA number (if appropriate) • number of refills authorized • "dispense as written" instructions (if indicated) • date of issuance of the prescription • name, strength, dosage form, and quantity of the drug prescribed and the drug dispensed originally and for each refill Payment is recouped for inappropriate payments for billings found in violation of policy.	Changed for clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	1.4 Co-Payments	The paragraph immediately following the bullets was changed to read: Providers may not refuse to render service if a beneficiary is unable to pay the co-payment amount at the time the service is provided. However, the uncollected co-payment is considered a bad debt which allows the provider to refuse to provide future services according to Michigan's State Plan. Providers who elect not to provide services based on a history of bad debt, including unpaid co-payments, must give beneficiaries appropriate verbal notice and a reasonable opportunity for payment.	Clarification
Practitioner	Section 3 – Early and Periodic Screening, Diagnosis, and Treatment	The second paragraph in the Outreach portion of the table was changed to read: When the **mihealth** card is issued, it is mailed with the MDCH publication "Michigan Free Health Check-Ups" (containing English, Spanish, and Arabic text). The publication explains the benefits of a well child visit, indicates the recommended periodicity schedule, describes procedures included in the free health checkup, and presents information about transportation.	Update name of brochure.
Practitioner	3.10 Referrals	The second sentence of the second paragraph was changed to: For information regarding billing a well child E/M visit and other E/M visits occurring on the same date of service, refer to the Evaluation and Management Section of this chapter.	Changed for clarification and consistency.
Practitioner	Practitioner Reimbursement Appendix (New)	Reimbursement related information in the following subsections of the chapter were relocated to the new Practitioner Reimbursement Appendix: 4.13 Injectables 7.5 Physician Emergency Department Two-Tier E/M Rate	Consolidated all reimbursement related information into single area of chapter.
Tribal Health Centers	2.2 Non-Enrolled Providers	The term "certified alcohol clinicians" was changed to "certified addiction counselors".	Correction.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Tribal Health Centers	Section 4 – Substance Abuse	The term "certified alcohol clinicians" was changed to "certified addiction counselors".	Correction.
Tribal Health Centers	Section 6 – Encounters	The first sentence of the second paragraph was changed to read: The HIS outpatient all-inclusve rate (AIR) is determined by the Centers for Medicare and Medicaid Services (CMS) and is published in the Federal Register.	Correction.
Tribal Health Centers	7.6 Place of Service	The first sentence was changed to read: THC services provided to beneficiaries at the THC are reconciled to the THC outpatient facility all-inclusive encounter rate or according to the signed MOA. The second paragraph was changed to read: The THC may bill for services that are not provided at the THC. However, these services must be billed with the appropriate POS code in compliance with the coverages and limitations specified in the Practitioner Chapter of this manual. Except for Maternal and Infant Support Services provided in the home, only services billed with the THC POS code will be reconciled to the all-inclusive encounter rate.	Correction.
Directory Appendix		New information added and existing information updated as appropriate.	Routine update.

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Michigan Department of Community Health

Medicaid Provider Manual
January 2005 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 04-24	12/1/04	Practitioner	4.21 Orthoptic Services	PA requirement for strabismus surgery was removed.
MSA 04-23	12/1/04	Medical Suppliers	2.19 Incontinent Supplies	The table of incontinent supply items that must be obtained from the MDCH Volume Purchase Contract was updated to reflect national procedure coding changes.
MSA 04-22	12/1/04	Practitioner	4.12 Immunizations (Vaccines and Toxoids)	Changes in coverage for vaccines for beneficiaries age 19 and older.
MSA 04-21	12/1/04	Pharmacy	13.6 Beneficiary Co-payments	$3 co-pay required for each brand drug dispensed whether a generic is available or not.
MSA 04-20	12/1/04	Billing & Reimbursement for Institutional Providers	8.2 Hospital Leave Days	Added information on new limitations on coverage of Hospital Leave Days.
		Hospice	6.3.H. Room and Board to Nursing Facilities	
MSA 04-19	12/1/04	Hearing and Speech Centers	Section 1 – Coverage Overview 2.1 Hearing Services 2.2 Speech Services	Updated certification/enrollment 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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
School Based Services 04-07	12/1/04	School Based Services	2.1 Individuals With Disabilities Education Act Assessment and IPE/IFSP Development, Review and Revision 2.7 Developmental Testing	The definition of procedure code 96111 was updated.
Medical Supplier 04-07	12/1/04	Medical Supplier	2.37 Prosthetics (Lower Extremities) 2.39 Speech Generating Devices 2.47 Wheelchairs, Pediatric Mobility Items and Seating Systems	Clarification of coverage.
All Provider 04-15	September 2004	Chiropractic Hearing Aid Dealer Pharmacy Practitioner	Table of Contents	Reinstated coverage of chiropractic, hearing aid, and podiatric services for beneficiaries 21 and older; implemented changes in pharmacy co-pay requirements and dispensing fees.
MSA 04-17	11/1/04	Hospital	Section 6 – Discharge Planning	Clarification of MSA 04-15.
MSA 04-16	11/1/04	Practitioner	Practitioner Reimbursement Appendix (New)	Payment adjustments for practitioner services provided through designated public entities.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 04-15	10/1/04	Hospital	Section 6 – Discharge Planning	Admission requirements for Medicaid Nursing Facilities, MI Choice Waiver, and PACE.
MSA 04-14	9/17/04	Hospital	5.11 Planning for Discharge (new name) Section 6 – Discharge Planning (new)	Updated information regarding Ventilator Dependent Care, Memorandums of Understanding. New Section 6 – Discharge Planning created. Information about ventilator dependent care units and nursing facility memorandum of understanding previously located in 5.11 Discharge Planning was updated and moved to new section. 5.11 was renamed Planning for Discharge.
SBS 04-06 SBS 04-03 SBS 04-02 SBS 03-04 SBS 03-01	11/1/04 5/21/04 4/1/04 10/15/03 12/20/02	SBS Administrative Outreach (new chapter)	New	All current information previously published in policy bulletins has been incorporated into the School Based Services Administrative Outreach Chapter.

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Michigan Department of Community Health

Supplemental Bulletin List

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

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

NOTE: The list does not include bulletins specific to Nursing Facilities. Nursing Facility providers should retain ALL of their previously issued provider-specific bulletins currently in effect until the Nursing Facility chapter is added to the electronic manual. Bulletins for Nursing Facility providers are available under the Medicaid Policy Bulletins portion of the website.

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
10/04	All Provider 04-16	Sanctioned Provider List	All Providers	The list of sanctioned providers is available on the MDCH website at www.michigan.gov/mdch >>Providers>>Information for Medicaid Providers >>List of Sanctioned Providers. Providers without access to the internet should retain this bulletin.
6/1/04	All Provider 04-05	New editing, explanation code crosswalk, and crossover claims.	All Providers	This bulletin will remain in effect until MDCH completes its implementation of the 835 remittance advice and crossover claims. Information will then be incorporated into the manual.