MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: MSA 05-18

Issued: March 1, 2005

Subject: Updates to the Medicaid Provider Manual

Effective: April 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 April 2005 update of the online version of the Medicaid Provider Manual. The update includes the addition of two new manual chapters--Nursing Facilities, and the Program of All-Inclusive Care for the Elderly (PACE). All policies related to these program areas are now incorporated into the online version of the manual.

The 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.

The second table describes changes made to incorporate information from recently issued Medicaid Bulletins. These changes appear in blue in the online version of the manual.

If changes were made in a chapter, a note will appear in the affected section/subsection title of that chapter's table of contents.

When utilizing the January 2005 compact disc (CD) version of the manual, refer to this bulletin in addition to the CD to assure you have the most current policy information available.

Manual Maintenance

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

Questions

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

Approved

Paul Reinhart, Director
Medical Services Administration

Michigan Department of Community Health

Medicaid Provider Manual
April 2005 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Manual Overview		"Outpatient Therapy Providers (PT 40)" was added to the list of affected providers for the Hearing & Speech Centers chapter.	Update
Billing & Reimbursement for Institutional Providers	6.7 Chemotherapy Treatment	The last sentence under the second bullet was deleted.	Deleted outdated information
Billing & Reimbursement for Institutional Providers	6.17 Emergency Department Services	The third bullet under the Emergency Department Non-Emergency Treatment Services was changed to read: All other services (e.g., **laboratory**, x-ray, etc.) must be billed consistent with Medicaid's FFS policy.	Update
Billing & Reimbursement for Institutional Providers	6.18 Gastro-Intestinal Services	The first bullet was changed to read: The room charge for use of gastro-intestinal services (e.g., Endoscopy, Laparoscopy) must be billed with revenue code 0750 and appropriate CPT/HCPCS code on the **claim**.	Correction
Billing & Reimbursement for Institutional Providers	6.24 Labor and Delivery Room	The last sentence in the subsection was changed to read: This test may not be billed with any Labor Room/Delivery 072X Revenue Code series.	Update
Billing & Reimbursement for Institutional Providers	6.26 Minor Surgery/Procedure	The last sentence in the subsection was changed to read: A list of CPT/HCPCS codes billable with 0361 is available on the MDCH website. (Refer to the Directory Appendix for website information.)	Update

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

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	6.32.A. Interventional Radiology	The following sentences were added to the first bullet: (A list of appropriate supporting codes is available on the MDCH website. Refer to the Directory Appendix for website information.)	Update
Billing & Reimbursement for Institutional Providers	6.36 Therapies (Occupational, Physical and Speech-Language)	The following codes were deleted from the list of dual-use CPT codes: 92610 and 97525 The following code was added to the list of dual-use CPT codes: 97535	Update
Billing & Reimbursement for Institutional Providers	8.1 Split Billing – Statement Covers Period (new subsection, subsequent subsections renumbered)	The following information was added as text to this new subsection: The Statement Covers Period on the claim is used for reporting the beginning and ending dates of service for the entire period reflected on the claim. In instances where the facility is split billing the month, the From and Through dates must be for only the period reflected on the claim. Example: Facility is split billing April. On the first claim, the From date would be 040105 and the Through date would be 041505 for 15 days. The second claim From date would be 041605 and the Through date would be 043005 for 15 days. If a patient-pay amount is involved on both claims, the facility is reminded that the first claim must be paid before submitting the second claim. Refer to the Patient-Pay portion of this section for additional information. Failure to follow the above claim completion instructions will result in unnecessary pending of claims and delays in processing.	Clarification
Billing & Reimbursement for Professionals	6.4 Ancillary Medicine Services	The first sentence in the Injectable Drugs portion of the table was changed to read: If an injectable drug, **except a vaccine,** is administered on the same day as another service, the administration of the drug is considered a part of the other service and cannot be billed separately.	Clarification

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<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td>Billing & Reimbursement for Professionals</td><td>7.6.I. Miscellaneous Supplies
(new subsection)</td><td>The following information was added to the new Miscellaneous Supplies subsection:
<table><tr><th>Modifier</th><th>Description</th><th>Special Instructions</th></tr><tr><td>U4</td><td>Pediatric supply item</td><td>Use with HCPCS code A7520 for pediatric neonatal tracheostomy tubes.
Use with HCPCS codes A4351 or A4352 for hydrophilic coated intermittent urinary catheters.</td></tr></table></td><td>Update</td></tr>
<tr><td>Children’s Special Health Care Services</td><td>5.4 Payment Agreement</td><td>The second sentence of the third paragraph was changed to read:
In the event the client/family contribution exceeds the costs expended by MDCH, a refund will be made for the difference between the MDCH expenditures and the amount contributed by the family.</td><td>Clarification</td></tr>
<tr><td>Children’s Special Health Care Services</td><td>9.1 Specialty Dental Benefits</td><td>A text box was added at the beginning of the subsection referring providers to the Dental Chapter for details regarding dental service coverages and limitations.</td><td>Clarification</td></tr>
<tr><td>Children’s Special Health Care Services</td><td>11.3 Travel Reimbursement for CSHCS Only Clients</td><td>The word “caretakers” in the first sentence of the last paragraph in the Meals portion of the table was changed to “caregivers”.</td><td>Clarification</td></tr>
<tr><td>Hearing Aid Dealers</td><td>1.11 Measurable Benefits/Hearing Aid Conformity Check</td><td>The first sentence of the first paragraph after the bullets was changed to read:
When a delivered hearing aid does not provide benefit, as defined above, providers are expected to return it to the manufacturer within 30 days for circuitry modifications, remake, exchange, or credit, as recommended by the evaluating audiologist.</td><td>Update</td></tr>
</table>

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital	1.4.E. Emergency Department Post-Payment Review	This subsection was deleted. Providers should refer to the Outpatient Hospital Post-Payment Review subsection for current information related to post-payment reviews.	Update
Hospital	5.2.C. PACER Readmissions	The second sentence of the second bullet was deleted.	Update
Hospital	5.3 Post-Payment Review of Transfers and Readmissions	The first sentence of this subsection was changed to read: Transfers and readmissions are reviewed on a post-payment basis **utilizing the audit process outlines in the Inpatient Hospital Post-Payment Reviews portion of this section**.	Clarification
Hospital	5.4 Inappropriate or Unnecessary Admissions	The last sentence in the third paragraph was changed to read: Charges resubmitted as outpatient charges are monitored, and any payment made **may be** recovered during a post-payment audit.	Update
Hospital	5.6 Utilization Review	The second paragraph was changed to read: Post-discharge utilization reviews of medical/surgical and rehabilitation stays are conducted by the ACRC **as part of the audit process described under the Inpatient Hospital Post-Payment Reviews portion of this section**.	Clarification

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital	5.7 Post-Payment Reviews	The subsection was renamed Inpatient Hospital Post-Payment Reviews. The first paragraph was changed to read: The Admissions and Certification Review Contractor (ACRC) performs periodic statistically-valid random sample audits of claims, by hospital, to verify that the inpatient hospital medical record supports the level of services billed. If a hospital's statistically-valid random sample audit 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. The following paragraph was added after the table: The ACRC contacts the inpatient hospital to be audited by telephone prior to the audit to arrange a date to obtain medical records. This is followed by a confirmation letter. The hospital is provided a list of beneficiaries (including beneficiary name, date of birth, and date(s) of service) to be audited 15 business days prior to the ACRC visit. If a selected beneficiary has multiple admissions during the audit period, records for all admissions are required. If the facility requires an extension of the timeframe to pull records, a request must be submitted via letter, email or fax to MDCH. Contact the ACRC for information regarding the submission process. The ACRC will copy/scan the records utilizing its own equipment. The hospital will be sent a copy of the audit results at the conclusion of the audit review.	Clarification
Hospital	5.9 Contractor Monitoring	The first sentence of the subsection was changed to read: MDCH monitors the ACRC's review **and audit** process and case determinations to verify that . . . . The first sentence of the last paragraph was changed to read: The ACRC may be monitored to assure timeliness of **the audit process**.	Clarification

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital	5.13 Outpatient Hospital Post-Payment Review	The subsection was changed to read: The ACRC performs periodic statistically-valid random sample audits, by hospital, of outpatient hospital services, to verify services provided, amount billed, and appropriateness of setting. Records are reviewed to assure that services were rendered in accordance with professionally recognized standards of care and in compliance with Medicaid coverage. All outpatient hospital services are eligible for this review and billing validation including, but not limited to, emergency department services, surgeries, endoscopies, and other special procedure room services. If a statistically-valid random sample by hospital determines that services billed were at a higher level than supported by the medical records, audit findings may be extrapolated to the entire Medicaid population receiving services in that facility for the designated timeframe of the audit, and are subject to recoupment and/or adjustment. The ACRC contacts the outpatient hospital to be audited by telephone prior to the audit to arrange a date to obtain medical records. This is followed by a confirmation letter. The hospital is provided a list of beneficiaries (including beneficiary name, date of birth, and date(s) of service) to be audited 15 business days prior to the ACRC visit. All outpatient services provided during the review period (e.g. laboratory, radiology, emergency room, physical therapy, etc.) for the beneficiaries included in the sample for the audit period, are required. Some of the services included may be ones that are series billed (e.g., physical therapy). In addition, an itemized list for revenue center codes may be requested. If the facility requires an extension of the timeframe to pull records, a request must be submitted via letter, email or fax to MDCH. Contact the ACRC for information regarding the submission process. The ACRC will copy/scan the records utilizing its own equipment. The hospital will be sent a copy of the audit results at the conclusion of the audit review.	Clarification
Hospital/ Reimbursement Appendix	2.8.F. Transfers From a Hospital	The last sentence of this subsection was deleted.	Removal of obsolete information.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital/ Reimbursement Appendix	8.5 Primary Care Pool	The following formula was added after the second paragraph: FTEs x (Hospital's Title V & Title XIX Outpatient Charges/Hospital's Total Charges) = Adjusted FTEs	Previously included information removed in error 10/1/04.
Hospital/ Reimbursement Appendix	11.13 Reopening of Settlements	The following was inserted after the fifth paragraph: To reopen a completed settlement using a filed cost report for an issue with Medicaid program data, the same reopening criteria regarding time limits will be used. However, once the final settlement has been calculated and the Medicaid audit adjustment report has been sent to the hospital, the Medicare/Medicaid CMS 2552 report will not be amended.	Inadvertently omitted when bulletin MSA 03-05 was incorporated into the manual.
Maternal & Infant Support Services	5.1 Criteria	The last sentence in the Nursing portion of the table was changed to read: All nurses must possess current Michigan licensure as a Registered Nurse.	Clarification.
Medical Supplier	1.8.C. Repairs and Replacement Parts	The sixth paragraph was changed to read: The replacement of a DME item will be considered when a significant change in the patient's condition has occurred or the cost of the equipment repair is greater than replacement. If the DME item cannot be restored to a serviceable condition and there has been no change in the medical condition of the beneficiary, MDCH will consider replacement if the existing equipment meets coverage criteria or was purchased by the program. In these cases, a current prescription will meet documentation requirements for the equipment. If there has been a change in the medical condition that would reflect a change in equipment need, then all documentation requirements in the Coverage Conditions and Requirements Section apply. Replacement of DME for youth will be evaluated on an individual basis due to the expected growth pattern.	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
		MDCH will not replace an item due to damage to the item as a result of misuse or abuse by the beneficiary or the caregiver. If damage to an item is the result of theft or car accident, attempts should be made to collect the full or partial payment from the third party's insurance company, if applicable. A copy of the police or fire report must be submitted with the PA request form.	
Mental Health/ Substance Abuse	4.5 Eligibility Criteria	A new category labeled "Discharge" was added to the end of the table with the following content: Cessation or control of symptoms is not sufficient for discharge from ACT. Recovery must be sufficient to maintain functioning without support of ACT. • The beneficiary no longer meets severity of illness criteria; has demonstrated the ability to meet all major role functions for a minimum period of one year as addressed in the Individual Plan of Service; and is transitioned into less intensive services. The transition plan includes appropropriate supports and services, beneficiary preferences, and a provision for return to ACT services if needed. • Engagement of the individual in ACT is not possible as deliberate, persistent and frequent assertive team outreach including face-to-face engagement attempts and legal mechnanisms, when necessary, have been consistent, unsuccessful, and documented over many months, and an appropriate alternative plan has been established with the beneficiary. • Beneficiary has moved outside of the geographic service area and contact continues until service has been established in the new location.	Clarification
Mental Health/ Substance Abuse	12.1 Covered Services	The third bullet was changed to read: • Any program/agency performing any or all portions of the AAR service must be appropriately licensed by the state.	Update

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	14.1 Key Provisions	The following sentences were added to the end of the third paragraph: All services and supports must be included in the Individual Plan of Services (IPOS). The IPOS must be received, approved and signed by the physician.	Clarification
Mental Health/ Substance Abuse	14.4.B. Individuals Performing Case Management Functions	The following sentence was added to the beginning of the subsection: Individuals performing case management functions must meet the requirements for a Qualified Mental Retardation Professional (QMRP) and have:	Clarification
Mental Health/ Substance Abuse	17.1 Definitions of Goals That Meet the Intents and Purpose of B3 Supports and Services	The last sentence of the second paragraph of the Independence portion of the table was changed to read: For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to **be successful in school**, enter adulthood and live independently. The following sentence was added as the second sentence in the second paragraph of the Productivity portion of the table: For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities.	Update
Pharmacy	1.1 MDCH Pharmacy Benefit Manager and Other Vendor Contractors	The term MPPL was defined as: Michigan Pharmaceutical Product List	Clarification
Pharmacy	1.2 Definitions	A new term "Out of State Pharmacy" was added to the table with the following definition: An entity not housed within the state of Michigan but registered by the Michigan Board of Pharmacy. An Out of State Pharmacist is required to be licensed in the state the pharmacy is located in.	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	1.4 Place of Service	The following information was added after the first bullet: Exception: Beneficiaries with a level of care (LOC) 02 can receive injectable drugs as a pharmacy benefit due to the relationship between the nursing facility and its contracted providers.	Clarification
Pharmacy	13.4.A. Discounted Average Wholesale Price	The description of the third pharmacy group listed in the table was changed to: Pharmacies who serve beneficiaries with a level of care (LOC) 02.	Clarification
Pharmacy	13.5 Dispensing Fees	The explanation of the dispensing fee for IV admixtures was changed to: $7.50 (single all-inclusive fee) plus standard dispensing fee	Clarification
Pharmacy	13.6 Beneficiary Co-Payment	The second bullet in the Over Age 21 Exclusions portion of the table was changed to read: The beneficiary is in a nursing facility (level of care 02, **55 or 56).**	Update
Pharmacy	15.1 Level of Care	The following information was added to the table: 55, 56 – Beneficiary is not eligible for NF services, but is eligible for pharmacy services.	Update
Pharmacy	15.2 Unit Dose Policy	The first sentence of the second paragraph was changed to read: Long-term care pharmacies who have unit dose agreements may be reimbursed for unit dose when the pharmacies **adhere to all of the following**:	Clarification
Pharmacy	15.7 Products Included in the Nursing Facility Per Diem Rate	The last sentence of the third bullet was changed to read: Examples of OTCs in the per diem include**, but are not limited to**:	Clarification

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	Section 19 – Pharmacy Audit and Documentation	The following sentences were added after the first sentence in the Prescription Documentation portion of the table: Physician affidavits will not be accepted for pharmacy documentation. Notation on a pharmacy's database is not considered a written form of the prescription.	Clarification
School-Based Services Administrative Outreach Program	6.2 Random Moment Sampling	The second sentence of the fifth paragraph was changed to read: Calculations verified by MDCH show that a sample of **384** moments statewide each quarter is adequate to obtain this precision. The last sentence of the last paragraph was changed to read: For this analysis, the 95% confidence interval for the estimated matchable time staff spends on activities eligible for the 50% matching rate will have an uncertainty of **2%**.	Update
School-Based Services Administrative Outreach Program	6.9 Summer Quarter Formula and Random Moment Time Study	The last sentence of the third paragraph was deleted. This information is included in subsection 6.2.	Update
Forms Appendix	MSA-2565-C	Form updated to reflect current policy. Electronic fill-in version available on the MDCH website at www.michigan.gov/mdch >>Providers>>Information for Medicaid Providers>>Medicaid Provider Forms and Other Resources	Update

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 05-15	3/1/05	MSS/ISS	2.10 Place of Service	Clarification on MSS/ISS visits performed in a community setting.
MSA 05-14	3/1/05	Nursing Facility (new)		New Nursing Facility Coverages & Limitations and Reimbursement chapters.
		Manual Overview		Nursing Facility added to the list of chapters included in the manual.
MSA 05-12	3/1/05	Medical Supplier	2.3 Blood Glucose Monitoring Equipment and Supplies	Standards of coverage for blood glucose monitoring equipment and supplies were updated.
			2.15 High Frequency Chest Wall Oscillation Device	Standards of coverage for a HFCWO device were clarified.
			2.16 Home Intravenous Infusion Therapy	Documentation requirements for anti-emetic infusion were added.
			2.19 Incontinent Supplies	Standards of coverage for pull-on briefs were updated.
			2.36 Pressure Gradient Products	Standards of coverage for gradient compression stockings and surgical stockings were added.
			2.38 Pulse Oximeter	Payment rules for the continuous use beyond 10 months or rental were added.
MSA 05-10	2/1/05	School Based Services Administrative Outreach Program	6.2 Random Moment Sampling	Changes the precision level for sampling to +/- 5% and the number of quarterly moments to be selected to 800.

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

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 05-09	3/1/05	Program of All-Inclusive Care for the Elderly (PACE) (new chapter)		Clarification of Nursing Facility Level of Care Determination for PACE.
		Hospital	6.8 Nursing Facility	Clarification of Nursing Facility Level of Care Determination added.
MSA 05-07	2/1/05	Program of All-Inclusive Care for the Elderly (PACE) (new)		New chapter PACE program eligibility, coverages, participation policies.
		Manual Overview		Program of All-Inclusive Care for the Elderly was added to the list of Manual chapters.
MSA 05-06	2/1/05	Adult Benefits Waiver	1.1 County-Administered Health Plans 1.3 Reimbursement Section 2 – Coverages and Limitations	Information related to the inpatient hospital benefit and co-pay requirement for emergency room services not resulting in an admission were removed. Pharmacy co-payment requirement was changed from $5/$10 to $1.
MSA 05-05	1/1/05	Hospice	6.3.H. Room & Board to Nursing Facilities	Hospice payments to Nursing Facilities include 95% of the facility's Medicaid payment rate plus 100% of the facility's Quality Assurance Supplement (QAS) rate.
MSA 05-04	1/1/05	Pharmacy Directory Appendix	5.1 Signature Log 13.6 Beneficiary Co-Payment	Implementation of an optional mail-order pharmacy program.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 05-03	1/1/05	Practitioner	24.3 Gynecologic Care (New subsection, subsequent subsections renumbered) 24.4 Maternity Care (Renumbered to 24.5)	Expansion of covered services for Certified Nurse Midwives.
Nursing Facilities 04-07	10/1/04	Nursing Facility	Nursing Facility Certification, Survey and Enforcement Appendix	Nursing Facility Chapter V (Certification, Survey and Enforcement) incorporated into the online Medicaid Provider Manual as the Certification, Survey and Enforcement Appendix of the Nursing Facility 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.

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
3/1/05	MSA 05-18	April 2005 Medicaid Provider Manual Updates	All Providers	4/1/05 Information incorporated into appropriate chapters of the online manual.
3/1/05	MSA 05-17	Rebasing DRG Rates, DRG Groups Update, Per Diem Update	Hospitals, Medicaid Health Plans	
3/1/05	MSA 05-16	Sanctioned Providers (monthly update)	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.
3/1/05	MSA 05-15	Place of Service	Maternal/Infant Support Services	4/1/05 Information added to Maternal/Infant Support Chapter Section 2.10.
3/1/05	MSA 05-14	Revised Nursing Facility Coverages & Limitations and Reimbursement Chapters	Nursing Facilities	4/1/05 New Nursing Facility Chapter added to manual.

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DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
3/1/05	MSA 05-12	New Coverage Criteria for Pull-On Briefs and Home Infusion Anti-Emetic Drugs; Clarification of Coverage Criteria for Glucose Monitoring Equipment/Supplies, High Frequency Chest Wall Oscillation (HFCWO) Device, and Pressure Gradient Garments/Surgical Stockings; and Clarification of Payment Rules for a Pulse Oximeter	Medical Suppliers	4/1/05 Information added to Medical Supplier Chapter Section 2.
2/1/05	MSA 05-10	School-Based Services Administrative Outreach Claiming Methodology Changes	Intermediate School Districts/Detroit Public Schools	4/1/05 Information added to SBS Administrative Outreach Program Chapter subsection 6.2.
3/1/05	MSA 05-09	Clarification to Nursing Facility Level of Care Determination Policy (MSA 04-15 and MSA 04-17)	Nursing Facilities, MI Choice, PACE, Hospitals, Hospice, MHP, Mental Health/Substance Abuse	4/1/05 Information added to Hospital, Nursing Facility (new), and PACE (new) chapters.
1/1/05	MSA 05-08	Sanctioned Providers (monthly update)	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.
2/1/05	MSA 05-07	Program of All-Inclusive Care for the Elderly (PACE)	All Providers	4/1/05 New PACE Chapter added to the manual.
2/1/05	MSA 05-06	Adult Benefits Waiver Changes	All Providers	4/1/05 Information added to the Adult Benefits Waiver Chapter.

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DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
1/1/05	MSA 05-05	Payments to Hospice Providers for Nursing Facility QAS	Hospice, Nursing Facilities	4/1/05 Information added to Hospice Chapter subsection 6.3.H.
1/1/05	MSA 05-04	Optional Mail Order Pharmacy Benefit	Pharmacy, Practitioners, Mental Health/Substance Abuse, FQHCs, Local Health Departments, Rural Health Clinics, Tribal Health Centers	4/1/05 Information added to Pharmacy Chapter subsections 5.1 and 13.6.
1/1/05	MSA 05-03	Expansion of Covered Services for Certified Nurse Midwives	Certified Nurse Midwives, Practitioner	4/1/05 Information added to the Practitioner Chapter subsections 24.3 and 24.4.
1/1/05	MSA 05-02	Medicare Crossover Claims with AdminaStar	Practitioners, FQHCs, Medical Suppliers, Vision, Rural Health Clinics, Local Health Departments	This bulletin will remain in effect until MDCH completes its implementation of crossover claims. Information will then be incorporated into the manual.
10/1/04	Nursing Facilities 04-07	Nursing Facility Certification, Survey and Enforcement	Nursing Facilities	4/1/05 New Nursing Facility Chapter added to manual.
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.

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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.