



DATABASE INSTRUCTIONS

Oral/Maxillofacial Surgeon

This document contains information for interpreting this Michigan Medicaid database. Providers are instructed to refer to the Michigan Medicaid Provider Manual and/or MSA Bulletins for specific coverage, reimbursement policies, and required forms. To access this information via the MDCH website, click hyperlink: [Medicaid Policy & Forms](#).

The database is available in two formats:

- PDF excel file for viewing and/or printing a page
- An Excel file for downloading data onto your computer

Data elements and descriptions for this database are as follows:

Data Element	Description
HCPCS Code	The HCPCS Level I (CPT) or Level II code used to denote a service.
Modifier (Mod)	Completed when a modifier identifies a set fee screen. For diagnostic tests, a blank cell denotes the global service. 26 = the professional component TC = the technical component UA = admitted or transferred to inpatient hospital UD = released/discharged from emergency department
Short Description	The short description of the service associated with the HCPCS code.
HCPCS Action Code	Action code indicates the new action taken since last published database, if applicable. If cell is blank, no change has occurred. A = Add procedure or modifier code D = Discontinue procedure or modifier code P = Payment change R = Re-activate discontinue/deleted procedure or modifier code
Non-Facility Fee (Non-Fac Fee)	The fee screen for professional services provided in a non-facility setting. If there is an "M" in the fee field, the code is manually priced and requires additional information. An "NA" in this field indicates this procedure is rarely or never performed in the non-facility setting. ("#" in the field indicates the facility/non-facility rate concept does not apply.)
Facility Fee (Fac Fee)	The fee screen for professional services provided in a facility setting. If there is an "M" in the fee field, the code is manually priced and requires additional information. An "NA" in this field indicates this procedure is rarely or never performed in the facility setting. ("#" in the field indicates the facility/non-facility rate concept does not apply.)
Prior Authorization (PA)	Indicates "Y" if code requires Prior Authorization.
Comments	Indicates if additional pertinent data and/or documentation is required for claim submission (or) provides clarification of HCPCS code revisions. <ul style="list-style-type: none"> • Documentation Required = Additional information required to process the claim (e.g. description of service, operative report) • Revised = denotes revisions to HCPCS codes other than reflected by an action code since last published database, if applicable.

Questions on the database should be directed to Provider Inquiry by phone at 1-800-292-2550 or e-mail to ProviderSupport@michigan.gov. Include your name, affiliation and phone number for contact information.