MSA
MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 11-39

Distribution: All Providers

Issued: September 1, 2011

Subject: Updates to the Medicaid Provider Manual; Database Update; Maternal Infant Health Program; Average Wholesale Price (AWP); HIPAA 5010 Update

Effective: As Indicated

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

Updates to the Medicaid Provider Manual

The Michigan Department of Community Health (MDCH) has completed the October 2011 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. Attachment II describes changes made to incorporate information from recently issued Medicaid bulletins. These changes appear in green in the online version of the manual. The October 2011 version of the Manual will be available on the MDCH website on October 1, 2011.

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.

Database Update

The MDCH Physicians, Practitioners and Medical Clinic database has been revised and updated. Among the changes, this database no longer lists specific code Relative Value Unit (RVU) payment policy indicators. Providers are reminded, however, that Medicaid will continue to apply the national definitions of global surgical packages and uniform payment policies for surgical services established by the Centers for Medicare and Medicaid Services (CMS), including site of service payment adjustments, bilateral and multiple surgeries, co-surgeons, and team surgeons. Providers are now referred to the CMS website for up-to-date code specific information regarding these payment policy adjustments referenced in the Medicare Fee Schedule Data Base (MFSDB).

Maternal Infant Health Program

Bulletin MSA 11-29 was issued August 1, 2011, to provide updates and policy clarification to the Maternal Infant Health Program. One component of this policy allowed additional maternal visits to be approved over the nine visits currently allowed in policy. Approval of the additional maternal visits has been placed on hold until systems issues can be resolved. Policy addressing Risk Identifier Assessment Visits will remain in place, with the effective date of September 1, 2011.

Average Wholesale Price (AWP)

As stated in bulletin MSA 10-48, First Data Bank will cease publication of its AWP data by September 2011. Should First Data cease publishing AWP data, MDCH will no longer have access to this pricing information for its 'Lower of' pricing logic for pharmacy claims. MDCH will continue to use Wholesale Acquisition Costs (WAC) in the pricing algorithm, as stated in bulletin MSA 10-48.

HIPAA 5010 Update

The implementation date for Health Insurance Portability and Accountability Act of 1996 (HIPAA) version 5010 is only four months away. MDCH will no longer accept electronic transactions in the 4010A1 format effective January 1, 2012. Electronic transactions submitted on January 1, 2012, must be in the version 5010 format. Providers should be actively testing now to ensure that claims can be paid in January. Instructions for Business-to-Business (B2B) testing, Companion Guides, and other important information can be found on the MDCH website www.michigan.gov/5010icd10. MDCH is also issuing additional HIPAA 5010 information in bulletin MSA 11-36.

Changes will be made to the Community Health Automated Medicaid Processing System (CHAMPS) online Direct Data Entry (DDE) for claim submission. MDCH will be offering DDE training starting in October 2011 to provide users with understanding of how these changes affect both the entry and/or adjustments of claims for each of the three invoice types (institutional, professional, and dental). New 5010 templates for claims submission will also be required. Providers must set up new templates for claims submission for any DDE claims submitted January 1, 2012 and after. Further information regarding these training sessions will be available to providers on the MDCH 5010 webpage.

Manual Maintenance

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. 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.

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
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Michigan Department of Community Health

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October 2011 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	Section 9 - Inpatient Hospital Authorization Requirements	New section added to address Prior Authorization Certification Evaluation Review (PACER) process. Information from other chapters was relocated here to centrally locate information. (Following sections were re-numbered.)	Compilation of subject material/ relocated for better placement of information
General Information for Providers	15.1 MDCH Medicaid Integrity Program Section	Subsection was re-named to read "MDCH Office of Health Services Inspector General." References to "MDCH Medicaid Integrity Program Section" were revised to read "MDCH Office of Health Services Inspector General".	Update
Beneficiary Eligibility	Section 2 - mihealth Card	In the 10th paragraph, "MDCH Medicaid Integrity Program Section" was revised to read " MDCH Office of Health Services Inspector General".	Update
Beneficiary Eligibility	2.1 Benefit Plans	Text was added addressing service type codes. The table was replaced in its entirety to reflect: • the deletion of the column titled "Included In: HIPAA 271 and EE Subsystem"; • the addition of columns titled "Funding Source" and "Covered Services (Service Type Codes)"; and • the addition of two benefit plans: ➢ Children's Serious Emotional Disturbance Waiver-DHS (SED-DHS) ➢ Non-Emergency Medical Transportation (NEMT)	Update
Beneficiary Eligibility	3.1 CHAMPS Eligibility Inquiry	In the 6th paragraph, the 1st bullet point was revised to read: • Providers can enter a single DOS or up to a 3-month DOS span. (NOTE: DOS is not required for a pending eligibility inquiry since a response is returned if a pending record exists in CHAMPS.)	Change 90-day DOS span to 3-month DOS span.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Dental Providers	8.2 Electronic Remittance Advice	Text was revised to address the 835 - Electronic Remittance Advice and implementation of the 835 - Electronic Remittance Advice Request for Billing Agent Change/Update form (MSA-1380).	Update
Billing & Reimbursement for Institutional Providers	5.2.B. Changes in Facility Ownership Split Billing	The bullet list was revised to read: • The first claim must show the appropriate patient status code and a "through" date equal to the last day of original ownership. • The second claim must show the "from" date as the first day of the new ownership. • The same admission date must be used on both claims. • If a PACER number was required for the admission, both claims must use the same PACER number. • "Change in ownership" must be stated in the remarks section on the second claim.	Clarification
Billing & Reimbursement for Institutional Providers	5.2.C. Special Circumstances for Hospital Readmissions and Transfers (new subsection; following subsections re-numbered)	New subsection text was relocated and revised from 5.3 Pre-Admission and Certification Evaluation Review.	Clarification and update
Billing & Reimbursement for Institutional Providers	5.2.E. Loss/Gain Medicaid Eligibility	The following was added as a 2nd paragraph: When Medicaid eligibility is determined retroactively, "Retroactive Eligibility" must be entered in the Remarks section of the inpatient hospital claim.	General information

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	5.2.H. Newborn Eligibility	In the 2nd and 3rd sentences, references to "the hospital may ..." were revised to read "the hospital must ...". The last sentence was revised to read: ... when a newborn Medicaid ID number is issued.	General update
Billing & Reimbursement for Institutional Providers	5.3 Pre-Admission and Certification Evaluation Review	Subsection deleted. Following subsections re-numbered. Information re-located to Section 9 - Inpatient Hospital Authorization Requirements in the General Information for Providers chapter, and to 5.2.C. Special Circumstances for Hospital Readmissions and Transfers subsection in the Billing & Reimbursement for Institutional Providers chapter.	Update and revision
Billing & Reimbursement for Institutional Providers	5.4 Rehabilitation Units	Subsection text was revised to read: For Medicare recognized distinct part rehabilitation units, MDCH recommends providers report the appropriate taxonomy code on all claims submitted, either electronically or by paper, to ensure proper adjudication. Within the institutional 837 4010A1 electronic format, report the valid taxonomy code in provider loop 2000A (billing/pay-to-provider taxonomy code). For paper claims, use the Code-Code field within the UB-04 claim form. The PACER number must be entered on the claim in the treatment authorization field.	Revised for clarification following PACER subject review
Billing & Reimbursement for Institutional Providers	Section 6 – Hospital Claim Completion - Outpatient	The 1st sentence was revised to read: Information in this section should be used in conjunction with the National Uniform Billing Committee (NUBC) Manual when preparing Outpatient Hospital claims.	Clarification -- addition of "outpatient"

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	6.1.G. Repetitive Services Billing	Paragraph was revised to read: MDCH follows Medicare's Repetitive Services billing for Medicaid covered services when billed appropriately.	Clarification
Billing & Reimbursement for Institutional Providers	6.1.H. Individual Consideration	Subsection was deleted.	Obsolete information -- no longer applicable
Billing & Reimbursement for Institutional Providers	6.2 Abortion (new subsection; following subsections re-numbered)	New subsection text reads: Physicians must certify on a completed Certification for Induced Abortion form (MSA-4240) that, for medical reasons, an abortion was necessary to save the life of the mother or the beneficiary's medical history indicates that the terminated pregnancy was the result of rape or incest. The physician who completes the MSA-4240 must also ensure completion of the Beneficiary Verification of Coverage form (MSA-1550) and is responsible for providing copies of the forms for billing purposes to any other provider (e.g., anesthesiologist, hospital, laboratory) that would submit claims for services related to the abortion. Copies of the MSA-4240 and the MSA-1550 are not required for claims for ectopic pregnancies or spontaneous, incomplete, or threatened abortions. Providers may attach copies of the MSA-4240 and the MSA-1550 to the claim or submit them via fax. Federal regulations require that these forms be submitted to Medicaid before reimbursement can be made for any abortion procedure. This process can eliminate submitting paper attachments for abortion claims and pre-confirms the acceptability of the completed forms, as well as reduces costly claim rejections. (Refer to the Forms Appendix for copies of MSA-4240 and MSA-1550. The forms are also available on the MDCH website. Refer to the Directory Appendix for website and contact information.)	Addition of billing instruction

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	6.3 Anesthesia	The 1st paragraph was revised to read: MDCH adopted Medicare's anesthesia billing guidelines. Under OPPS, anesthesia services are packaged services, with items and services considered an integral part of another service being included in the APC payment for that integral part. Anesthesia, routine supplies, recovery room, and most drugs are considered an integral part of a surgical procedure, so payment of these items is packaged into the APC payment for the surgical procedure. The following was added after the 1st paragraph: Providers must bill all packaged items and services appropriately.	Clarification under MDCH's OPPS
Billing & Reimbursement for Institutional Providers	6.5 Apheresis (new subsection; following subsections re-numbered)	New subsection text reads: MDCH aligns as closely as possible with Medicare's billing and reimbursement guidelines for Apheresis services.	Addition of billing instruction
Billing & Reimbursement for Institutional Providers	6.7 Blood and Products (new subsection; following subsections re-numbered)	New subsection text reads: MDCH aligns as closely as possible with Medicare's billing and reimbursement guidelines for billing blood or blood products.	Addition of billing instruction
Billing & Reimbursement for Institutional Providers	6.7.A. Transfusion Services (new subsection)	New subsection text reads: MDCH aligns as closely as possible with Medicare's billing and reimbursement guidelines for transfusion services.	Addition of billing instruction
Billing & Reimbursement for Institutional Providers	6.7.B. Unused Blood	New subsection text reads: MDCH aligns with Medicare's billing and reimbursement guidelines for blood bank unused blood, processing and storage costs. The OPPS provider must not bill the beneficiary for these storage costs.	Addition of billing instruction

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	6.8 Clinic Services	New subsection text reads: MDCH aligns as closely as possible with Medicare's billing and reimbursement guidelines for billing Hospital Clinic services rendered in a clinic setting that is part of the licensed, Medicaid enrolled hospital, and that satisfy Medicare requirements for provider-based status. Clinic services rendered in the outpatient hospital include nonemergency outpatient services that are provided to ambulatory beneficiaries. (Following subsections re-numbered)	Addition of billing instruction
Billing & Reimbursement for Institutional Providers	6.10 Hemodialysis and Peritoneal Dialysis	Subsection title was revised to read: Dialysis (Hemodialysis and Peritoneal) Subsection relocated (to 6.12) for alphabetical listing format. Following subsections re-numbered.	Align with Hospital Chapter reference
Billing & Reimbursement for Institutional Providers	6.11 Diabetes Self-Management Education (DSME) Training Program	New subsection text reads: MDCH follows Medicare's DSME Training (initial and follow-up) billing guidelines as closely as possible. Providers must bill appropriately. All documentation must support services furnished are provided by a certified, Medicaid enrolled provider in the appropriate place of service. (Following subsections re-numbered)	Addition of billing instruction
Billing & Reimbursement for Institutional Providers	6.15 Observation Care Services	The subsection name was revised to read: Outpatient Observation Services Text was revised to read: MDCH follows Medicare's observation care services coverage, claim submission, and reimbursement policies when billed appropriately.	Clarification under MDCH's OPPS and align with Medicare billing manual reference/access for searching information

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	6.16 Hyperbaric Oxygen Therapy	New subsection text reads: MDCH follows Medicare's Hyperbaric Oxygen Therapy billing guidelines as closely as possible when billed appropriately. (Following subsections re-numbered)	Addition of billing instructions
Billing & Reimbursement for Institutional Providers	7.16 Long-Term Care Insurance	New subsection text reads: The Coordination of Benefits Chapter states that federal regulations require all identifiable resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. If a Medicaid beneficiary has long-term care insurance, it is recognized as another resource and that resource must be billed prior to billing Medicaid. In the event the facility is aware that a beneficiary has another resource (including long-term care insurance) but the resource is not reflected on the mihealth card or the Community Health Automated Medicaid Processing System (CHAMPS) eligibility inquiry, the facility must complete the Request to Add, Terminate or Change Other Insurance (form DCH-0078). (Refer to the Forms Appendix for a copy of the form and additional instructions.) The form should be submitted before billing Medicaid. If known, include the policy's per diem payment amount in the comments section of the form. Medicaid TPL will verify the information provided and update the beneficiary's CHAMPS eligibility information accordingly. The facility should bill the other resource first. Once payment has been received, the facility may bill Medicaid. The billing to Medicaid must include the payment amount received from the other resource.	Information added to assist nursing facilities.
Billing & Reimbursement for Institutional Providers	9.1 Direct Billing to MDCH	The 1st sentence was revised to read: Providers must bill MDCH directly (either paper or electronically) using the procedure codes listed in the Private Duty Nursing Reimbursement Rates database posted on the MDCH website.	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	9.1 Direct Billing to MDCH	In the table, text for "Plan of Care" was deleted. The following information was added to the table: **Other Insurance** - If the beneficiary has other insurance, it must be reported on all claims to MDCH.	Update
Billing & Reimbursement for Institutional Providers	11.2 Electronic Remittance Advice	Text was revised to address the 835 - Electronic Remittance Advice and implementation of the 835 - Electronic Remittance Advice Request for Billing Agent Change/Update form (MSA-1380).	Update
Billing & Reimbursement for Professionals	Section 3 - Claim Completion	In the chart, Item 23/Explanation, the 2nd paragraph was revised to read: If billing for clinical lab services, the CLIA certification number must be reported in this field.	Clarification
Billing & Reimbursement for Professionals	6.16.A. Direct Billing to MDCH	The 1st sentence was revised to read: Providers must bill MDCH directly (either paper or electronically) using the procedure codes listed in the Private Duty Nursing Reimbursement Rates database posted on the MDCH website.	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Professionals	6.16.A. Direct Billing to MDCH	In the table: • Text for "Plan of Care" was deleted. • The following information was added to the table: **Other Insurance** - If the beneficiary has other insurance, it must be reported on all claims to MDCH. • Under "Multiple Beneficiaries Seen at Same Location," the 1st sentence of the 2nd paragraph was moved to the 1st paragraph; the 2nd sentence of the 2nd paragraph was deleted. • Under "Holidays," the following sentence was added at the end of the paragraph: "A holiday begins at 12:00 a.m. and ends at 12:00 midnight of that holiday day."	Update
Billing & Reimbursement for Professionals	6.19 Surgery	Under "Global Surgery," the 3rd sentence was deleted.	Clarification due to revision of database
Billing & Reimbursement for Professionals	7.1 General Billing	Information for Modifier 22 was revised to read: Description: Increased Procedural Services Special Instructions: Providers may report when the work required to provide a service is substantially greater than typically required. Documentation/remarks required.	Updated to reflect current title and definition
Billing & Reimbursement for Professionals	8.2 Electronic Remittance Advice	Text was revised to address the 835 - Electronic Remittance Advice and implementation of the 835 - Electronic Remittance Advice Request for Billing Agent Change/Update form (MSA-1380).	Update
Dental	4.1.B. Authorization Instructions	Subsection deleted. Information re-located to the Inpatient Hospital Authorization Requirements section in the General Information for Providers chapter Following subsection re-numbered.	Update

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Dental	Section 7 - Noncovered Services	The 1st bullet point was revised to read: • Orthodontics	Clarification
Hearing Aid Dealers	2.10.C. Prior Authorization Requirements	In the 1st paragraph, the 2nd bullet point was revised to read: • … are less than or equal to the maximum payment limit as published in the Hearing Aid Dealers database (posted on the MDCH website) for hearing aids that are … In the 2nd paragraph, the 1st bullet point was revised to read: • The requested payment amount is over the maximum payment limit as published in the Hearing Aid Dealers database (posted on the MDCH website). (Refer to the Directory Appendix for website information.) The 3rd paragraph was revised to read: Repairs that are expected to exceed either the maximum payment limit or two episodes within 365 days require PA. Documentation (manufacturer's actual invoice) must be submitted with the MSA-1653-B PA request. If the manufacturer's actual invoice is not included, medical review staff will assign a penny screen to the code until the invoice is received.	Update
Hearing Services	2.4.B. Cochlear Implant Replacement Part Maximums	The table was deleted and text was revised to read: Refer to the Provider Specific Hearing Aid Services webpage for the list of approved cochlear implant replacement parts and maximums. (Refer to the Directory Appendix for website information.)	Update
Hearing Services	2.5 Replacement of Auditory Osseointegrated Devices	The 1st sentence was revised to read: … and will not be covered more frequently than once every four years.	Update

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CHAPTER	SECTION	CHANGE	COMMENT
Hearing Services	2.6 Reimbursement for Procedure Codes Identified with Not Otherwise Covered (NOC) or $0.01 Screen	The subsection heading was revised to read: Reimbursement for Procedure Codes Identified with Not Otherwise Classified (NOC) or $0.01 Screen Addition of 2nd paragraph which reads: The manufacturer's actual invoice must be submitted showing the actual price paid for the product. If the manufacturer's actual invoice is not included, medical review staff will assign a penny screen to the code until the invoice is received.	Clarification
Hospice	5.6 Categories of Care	Under "General Inpatient Care," the 2nd sentence was revised to read: This brief episode of care is usually for pain control, or acute or chronic symptom management, that cannot be reasonably treated in another setting.	Clarification
Hospice	5.7.D. Adult Home and Community Based Waiver Beneficiaries (MI Choice)	In the 1st paragraph, the 1st sentence was revised to read: If the beneficiary is enrolled in the waiver program, the hospice must contact the beneficiary's waiver coordinator/agent. In the 4th paragraph, the 1st sentence was revised to read: ... before additional waiver services of the same type are provided. In the 4th paragraph, the 3rd sentence was revised to read: If inappropriate (e.g., duplicative) waiver services were provided, MDCH will seek recovery of ...	Clarification
Hospital	Section 2 - Prior Authorization	In the chart, subject matter for "Elective Admissions, All Re-admissions, Transfers for treatment of general medical conditions" was removed. Information re-located to the Inpatient Hospital Authorization Requirements section in the General Information for Providers chapter	Update

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.4 Anesthesia	In the 1st paragraph, the 1st sentence was revised to read: Medicaid policy coverage ... The following text was inserted after the 1st paragraph: Medicaid does not cover anesthesia services related to the treatment of infertility.	Clarification
Hospital	3.6 Apnea Monitors	In the 1st paragraph, the 1st sentence was revised to read: Medicaid policy guidelines for home apnea monitors are based on ...	Clarification
Hospital	3.7.A. Childbirth Education	In the 1st paragraph, the 1st sentence was revised to read: MDCH covers childbirth education programs for pregnant women.	Clarification
Hospital	3.7.B. Diabetes Self-Management Education Training Program	The subsection title was revised to read "Diabetes Self-Management Education (DSME) Training Program". Subsection text was revised to read: MDCH covers diabetes self-management education (DSME) when ordered by a physician and provided by diabetes educators (e.g., nurse, dietitian) in a Medicaid enrolled outpatient hospital or a Local Health Department (LHD) which has been certified by MDCH Public Health Administration. Certification information must be provided to MDCH via the CHAMPS Provider Enrollment on-line system. (Refer to the Directory Appendix for contact information.) This service is not covered if rendered by a physician in the office setting, rendered by a nonenrolled provider, or rendered by a non-CPH certified provider. MDCH follows Medicare's DSME training billing guidelines.	Clarification
Hospital	3.7.C. Kidney Disease Education (KDE) Services	In the 1st paragraph, the 1st sentence was revised to read: MDCH covers kidney disease education (KDE) ...	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.8 Blood Products	Subsection text was revised to read: MDCH coverage aligns with Medicare OPPS coverage and billing guidelines as closely as possible for Blood Processing/Storage in an outpatient hospital. Providers must bill appropriately following the Medicare coding and reporting requirements.	Clarification
Hospital	3.9 Chemotherapy Treatment	The 1st sentence was revised to read: MDCH covers antineoplastic drugs.	Clarification
Hospital	3.12 Dialysis (Hemodialysis and Peritoneal Dialysis)	In the 1st paragraph, the 1st sentence was revised to read: MDCH coverage and reimbursement is an all-inclusive rate for … In the 1st paragraph, the following was inserted after the 1st sentence: MDCH follows the Medicare billing guidelines for hemodialysis and peritoneal dialysis.	Clarification
Hospital	3.13 Diagnostic Testing	In the 1st paragraph, the 1st sentence was revised to read: MDCH policy covers and reimburses for diagnostic testing to diagnose a disease or medical condition. In the 1st paragraph, the 4th sentence was revised to read: Outpatient hospitals must bill appropriately under MDCH's OPPS. In the 2nd paragraph, the 1st sentence was revised to read: MDCH policy coverage does not reimburse for: …	Clarification
Hospital	3.13.B. Pediatric Multi-Channel Recording	In the 2nd paragraph, the 1st sentence was revised to read: MDCH policy covers two multi-channel recordings per year per beneficiary under age 21 when provided by qualified personnel and interpreted by the physician.	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.14.A. Screening Exam and Stabilization	In the 2nd paragraph, the 1st sentence was revised to read: Medicaid policy covers the medical screening examination, ...	Clarification
Hospital	3.16 Hyperbaric Oxygen Therapy	In the 1st paragraph, the following text was inserted after the 1st sentence. MDCH follows Medicare's billing guidelines.	Clarification
Hospital	3.18 Injections/Intravenous Infusions	In the 1st paragraph, the 1st sentence was revised to read: MDCH covers intramuscular, subcutaneous or intravenous injections and intravenous (IV) infusions when medically necessary.	Clarification
Hospital	3.19 Labor & Delivery/Nursery	In the 1st paragraph, the 1st sentence was revised to read: MDCH covers the labor and/or delivery room(s) or when an active labor does not progress to delivery.	Clarification
Hospital	3.20 Laboratory	In the 2nd paragraph, the 1st sentence was revised to read: MDCH policy covers hospitals for medically necessary laboratory tests when:	Clarification
Hospital	3.20.D. Microbiology Studies	Text was revised to read: MDCH coverage and reimbursement for ...	Clarification
Hospital	3.22 Observation Services	The subsection title was revised to read "Outpatient Observation Services". (relocated due to alphabetical listing; following subsections renumbered)	Clarification
Hospital	3.26 Radiology	In the 1st paragraph, the 1st sentence was revised to read: MDCH covers Medicaid enrolled hospitals for the following ...	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.28 Sterilization	In the 1st paragraph, the following was inserted as the 1st sentence. MDCH covers sterilization procedures when specific requirements are met. In the 3rd paragraph, the 1st sentence was revised to read: Federal regulations require that the completed MSA-1959/HHS-687 must be submitted to MDCH ...	Clarification
Hospital	3.29 Surgery	The 2nd paragraph was revised to read: When an ambulatory surgery is performed in the inpatient hospital setting, the physician/dentist must provide exception rationale justifying the need for an inpatient setting. Acceptable rationale includes: ... The 2nd bullet point was revised to read: • A pre-existing condition that significantly ... The 3rd bullet point was revised to read: • ... and the surgeon determines that additional surgical procedures are necessary. In the 3rd paragraph, "Pre-Admission and Certification Evaluation Review (PACER) " was revised to read "Prior Authorization Certification Evaluation Review (PACER)". The 5th paragraph was revised to read: MDCH covers a second surgical opinion if the beneficiary or the physician/dentist requests one.	
Hospital	3.29.A. Operating Room	The 1st paragraph was revised to read: Inpatient coverage and reimbursement is through the DRG payment.	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.29.B. Recovery Room	In the 1st paragraph, the 1st sentence was revised to read: MDCH policy covers routine … The 2nd paragraph was revised to read: Inpatient coverage and reimbursement is through the DRG payment. The 3rd paragraph was revised to read: Outpatient providers must bill appropriately for the Recovery Room. MDCH follows Medicare's coverage and reimbursement policies for outpatient providers.	Clarification
Hospital	3.29.C. Cosmetic Surgery	The 2nd sentence was revised to read: The physician/dentist must furnish the hospital with a copy of the PA letter for the surgery, as well as the PACER number for the admission.	Clarification
Hospital	3.34 Weight Reduction	In the 1st paragraph, the 1st sentence was revised to read: MDCH policy covers obesity treatment when …	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	Section 4 – Noncovered Services	The following items were added to the bullet list: • Items or services that are determined to be experimental or investigational are not covered benefits • Routine screening, such as spirometry, holter monitor, Doppler flow-study or pelvic echography • Testing to establish baseline values • Testing for the general health and well-being of a beneficiary • Screening or routine laboratory testing, except as specified for EPSDT Program or by Medicaid policy • "Profiles", "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the beneficiary's specific condition; or multiple laboratory tests performed as a part of the beneficiary evaluation if the history and physical examination do not suggest the need for the tests • Apheresis is not a covered service when a beneficiary donates blood preoperatively and, at a later date, the blood is transfused back to the beneficiary • MDCH does not cover antineoplastic agents that are investigational or experimental.	Update and clarification
Hospital	5.2 Pre-Admission and Certification Evaluation Review DRG Inpatient Admissions	Subsections deleted. Information re-located to the Inpatient Hospital Authorization Requirements section in the General Information for Providers chapter. Following subsections re-numbered.	Update
Hospital	5.3 Post-Payment Review of Transfers and Readmissions	Subsection deleted. Information re-located to the Inpatient Hospital Authorization Requirements section in the General Information for Providers chapter. Following subsections re-numbered.	Update

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	5.4 Inappropriate or Unnecessary Admissions	Subsection deleted. Information re-located to the Inpatient Hospital Authorization Requirements section in the General Information for Providers chapter. Following subsections re-numbered.	Update
Hospital	5.5 Authorization for Non-DRG Admissions to Freestanding Rehabilitation Hospitals	Subsection deleted. Information re-located to the Inpatient Hospital Authorization Requirements section in the General Information for Providers chapter. Following subsections re-numbered.	Update
Hospital Reimbursement Appendix	8.6 Definitions/Notes	Text for "Hospital's Case Mix" was deleted. Text was added as follows: **Hospital's Non-Traditional Case Mix:** The sum of the hospital's payments for all Medicaid admissions divided by the number of Medicaid admissions during the period covered. This figure is then divided by the hospital's price or rate.	Correction
Medical Supplier	2.24 Orthopedic Footwear	Under "PA Requirements," the 4th bullet point, the 3rd sub-bullet point was revised to read: ➢ Talipes Equinovarus (Clubfoot)	Correction
Nursing Facility Certification, Survey & Enforcement Appendix	Throughout the Appendix	References to "Michigan Department of Community Health, Bureau of Health Systems" were revised to read "Michigan Department of Licensing and Regulatory Affairs, Bureau of Health Systems."	Update

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Michigan Department of Community Health

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	Throughout the Appendix	References to "Michigan Department of Community Health, Bureau of Health Systems" were revised to read "Michigan Department of Licensing and Regulatory Affairs, Bureau of Health Systems."	Update
Practitioner	3.8.B. Diabetes (Type 2)	In the 2nd paragraph, the 2nd sentence was revised to read: Children at risk should be tested in accordance with current guidelines.	Clarification
Practitioner	5.2 Chemotherapy Administration	In the 8th paragraph, the 2nd sentence was revised to read: (Refer to the MDCH Physician Administered Drugs and Biologicals Database on the MDCH website for a listing of covered chemotherapy drugs.)	Clarification related to updates to databases
Practitioner	Section 6 - Evaluation and Management Services	In the 4th paragraph, the 1st sentence was revised to read: Do not report the modifier for increased procedural services with E/M services in order to request individual consideration, unless specifically directed by this manual.	Clarification
Practitioner	6.6 Nursing Facility Services	In the 3rd paragraph, the following text was inserted after the 2nd sentence: Providers may report modifier 22.	Clarification
Practitioner	10.1.B. Multiple Services on Same Day	In the 1st paragraph, the 5th sentence was deleted.	Obsolete information due to revision of database
Practitioner	Section 11 - Hospital Inpatient Physician Services	Text was revised to read: Medicaid covers physician services to hospital inpatients that are medically necessary and follow the requirements in this section.	Update

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	11.1 Admission 11.2 Pre-Admission and Certification Evaluation Review	Subsections deleted. Information re-located to the Inpatient Hospital Authorization Requirements section in the General Information for Providers chapter. Following subsections re-numbered.	Update
Practitioner	12.1 Global Surgery	The 2nd paragraph was deleted.	Obsolete information due to revision of database
Practitioner	12.3 Bilateral Surgery	The 2nd paragraph was revised to read: Reimbursement for a bilateral procedure reported appropriately with modifier 50 is based on the lower of the amount billed or 150 percent of the fee screen for the procedure.	Clarification due to revision of database
Practitioner	12.6 Multiple Surgeons	The 3rd sentence was revised to read: Medicaid reimbursement policy is based on CMS guidelines for Medicare services for multiple surgeons.	Clarification due to revision of database
Practitioner	12.11 Destruction of Lesions	The 2nd paragraph was revised to read: Coverage of the surgical destruction of lesions that involve 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 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.	Clarification due to revision of database

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CHAPTER	SECTION	CHANGE	COMMENT
Private Duty Nursing	1.1 Enrollment Requirements	Under "Private Duty Nursing", the 1st bullet point was revised to read: Be accredited by the Community Health Accreditation Program (CHAP) or the Accreditation Commission for Health Care (ACHC) as a PDN agency; or be accredited by the Joint Commission as a Home Health Agency; or be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) …	Clarification
Private Duty Nursing	1.3 Prior Authorization	In the 1st paragraph, the 1st sentence was revised to read: PDN services must be authorized by the Program Review Division, the Children's Waiver, or the Habilitation Supports Waiver before services are provided.	Clarification
Private Duty Nursing	1.4 Other Insurance	The 3rd paragraph was revised to read: If a beneficiary's commercial insurance does not cover PDN, the PDN agency, RN or LPN must inform the MDCH Program Review Division prior to billing MDCH. (Refer to the Directory Appendix for contact information.) A copy of the letter of explanation or explanation of benefits (EOB) must be kept in the beneficiary's medical record. Once it has been established that …	Clarification
Private Duty Nursing	1.7 Service Log	In the 4th paragraph, the following was added as the 1st sentence: Each signature must be accompanied by a date.	Clarification
School Based Services	1.6 Service Expectations	In the 2nd paragraph, the 2nd sentence was revised to read: … enhancing vocabulary, improving sentence structure, and reading).	removal of repetitive text
School Based Services Random Moment Time Study	9.2.B. MDCH Medicaid Integrity Program Section – Post Payment Review and Compliance	The subsection title was revised to read "MDCH Office of Health Services Inspector General - Post Payment Review and Compliance". In the 1st paragraph, the 1st sentence was revised to read: MDCH Office of Health Services Inspector General staff responsibilities are: …	MDCH organizational update

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Acronym Appendix		Revision: PACER = Prior Authorization Certification Evaluation Review	Correction in terminology
Directory Appendix	Throughout the Appendix	References to "Michigan Department of Community Health, Bureau of Health Systems" were revised to read "Michigan Department of Licensing and Regulatory Affairs, Bureau of Health Systems."	The Bureau of Health Systems was transferred from the Michigan Department of Community Health to the Michigan Department of Licensing and Regulatory Affairs.
Directory Appendix	Prior Authorization (Authorization of Services)	Addition of: Contact/Topic: MDCH Office of Health Services Inspector General Phone#: 800-622-0276 Fax#: 517-335-0075 Mailing/Email/Web Address: MDCH Program Review Division P.O. Box 30170 Lansing, MI 48909-7979 Information Available/Purpose: Inquiries by beneficiaries and providers regarding pharmacy and primary care restrictions	Update
Directory Appendix	Prior Authorization (Authorization of Services)	In the 7th row (Prior Authorization – Private Duty Nursing FFS Medicaid & CSHCS) references to "CSHCS" were removed.	obsolete information; PDN is not a covered benefit under CSHCS
Directory Appendix	Prior Authorization (Authorization of Services)	The 9th row (Prior Authorization – Private Duty Nursing MI Choice Waiver) was deleted.	obsolete information; PA is not required for PDN services under the MI Choice Waiver

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Billing Resources	Under "Automated Billing Unit/Electronic Billing Resources": Addition of Fax Number: 517-335-5570	
Directory Appendix	Billing Resources	Under "Centers for Medicare & Medicaid Services (CMS)", text for "Information Available/Purpose" was revised to read: Provider resource for CMS guidelines, HCPCS Codes, and National Physician Fee Schedule Relative Value Files	Clarification
Directory Appendix	Nursing Facility Resources	Under "MDS", web address information was revised to read: www.cms.hhs.gov/medicaid/mds3.0/	Update
Directory Appendix	Reporting Fraud, Abuse, or Misuse of Services	"Beneficiary Monitoring Program" information was moved to the "Prior Authorization (Authorization of Services)" section of the Appendix and re-named "MDCH Office of Health Services Inspector General."	Update
Directory Appendix	Reporting Fraud, Abuse, or Misuse of Services	References to "MDCH Medicaid Integrity Program Section" were revised to read "MDCH Office of Health Services Inspector General".	Update
Forms Appendix	MSA-1380	Addition of new form: "835 - Electronic Remittance Advice Request for Billing Agent Change/Update"	Update
Forms Appendix	MSA-1324	References to "Michigan Department of Community Health, Bureau of Health Systems" were revised to read "Michigan Department of Licensing and Regulatory Affairs, Bureau of Health Systems."	Update

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 11-33	8/1/2011	Children's Special Health Care Services	Section 10 – Out-Of-State Medical Care	The 2nd and 3rd paragraphs were revised to read: Non-emergency medical care related to the qualifying diagnosis is defined as not meeting the definition of emergency medical care stated above. Out-of-state non-emergency medical care is covered only when the service has been prior authorized by MDCH. Prior authorization requests for out-of-state services may be approved when all of the following criteria are met: • The requested service is related to the CSHCS qualifying diagnosis; • The request for out-of-state referral is submitted by the appropriate, CSHCS-authorized in-state subspecialist with whom the client will maintain a relationship following the out-of-state services, explaining the reason the requested service must be provided out-of-state; • The in-state subspecialist and the out-of-state specialist maintain a collaborative relationship with regard to determining, coordinating, and providing the client's medical care, including a plan to transition the client back to in-state services as appropriate; • Comparable care (the term "comparable care" does not require that services be identical) for the CSHCS qualifying diagnosis cannot be provided within the State of Michigan; • The requested service is accepted within the context of current medical standards of care as determined by MDCH; • The service has been determined medically necessary by MDCH because the client's health would be endangered if he were required to travel back to Michigan for services, if applicable. All out-of-state providers must complete the Community Health Automated Processing System (CHAMPS) enrollment process described in the Provider Enrollment Section of the General Information for Providers Chapter to submit claims to MDCH. Out-of-state pharmacies must be enrolled with the MDCH Pharmacy Benefits Manager to submit claims for payment.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 11-32	8/1/2011	Billing & Reimbursement for Institutional Providers	7.15 Medicare - Medicaid Nursing Facility Crossover Claims with Group Health Incorporated (GHI) (Coordination of Benefits)	New subsection text reads: MDCH accepts institutional crossover claims from the Coordination of Benefits Contractor, Group Health Incorporated (GHI). The institutional nursing facility crossover claim process allows nursing facilities to submit a single claim for residents dually eligible for Medicare and Medicaid. After processing the Medicare portion, GHI forwards the claim to Michigan Medicaid for processing and reimbursement. A remittance advice (RA) is generated from Medicare with the details of the Medicare payment and Remark Code MA07 (the claim information has also been forwarded to Medicaid for review). If this remark code does not appear on the Medicare RA, a separate claim must be submitted to MDCH. Once Medicare payment is received by the facility and Remark Code MA07 appears on the Medicare RA, the claim should appear on the Medicaid RA within 30 days. The facility may check claim status online through CHAMPS. If the claim does not appear in CHAMPS within 30 days, a claim should be submitted directly to MDCH showing all Medicare payment information. Providers must resolve denied claims with Medicare when there is a denied Medicare service not covered by Medicaid. The excluded Medicare service covered by Medicaid should be billed directly to Medicaid. The following claims are excluded from the crossover process: • Original Medicare claims paid in full without deductible or co-insurance remaining; • Claims with private and commercial insurance; • Adjustment claims fully paid without deductible or co-insurance; • Original Medicare claims paid at greater than 100% of submitted charges without deductible or co-insurance remaining;

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				• 100% denied original claims; • 100% denied adjustment claims, with no additional beneficiary liability; • 100% denied original claims, with additional beneficiary liability; • 100% denied adjustment claims, with additional beneficiary liability; • Adjustment claims; • Mass adjustment claims - other (monetary or non-monetary); • Medicare secondary payer cost-avoided (fully denied) claims; and • Claims reporting Revenue Code 0160 (Medicaid Reimbursement for a Nursing Facility Bed Following a Qualifying Medicare Hospital Stay). **Note**: • For any Medicare Part B services associated with this nursing facility claim, the facility would bill Medicare accordingly. • Nursing facilities must continue to complete their claims as they have been doing for Medicare. • Nursing facilities must report the beneficiary's patient-pay, any offset to the patient-pay amount, and voluntary payments on the claim submitted to Medicare. • When reporting ancillary services, the facility must indicate the service date on the line level of the claim. (Refer to applicable subsections in this chapter for additional information regarding ancillary services.)

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Ventilator - Dependent Care Units Medicaid-enrolled ventilator-dependent care units have a distinct National Provider Identifier (NPI) number for Medicaid billing. The number is separate from the "regular" facility NPI number. The facility would use the "regular" NPI number to bill days 1 to 100 to Medicare. Starting on day 101, the facility would bill Medicaid directly using its ventilator-dependent care unit distinct NPI number. Additional information regarding crossover claims is available on the MDCH website. (Refer to the Directory Appendix for website information.)
MSA 11-31	8/1/2011	Hospital	6.7 Private Duty Nursing	In the 4th paragraph, the 1st sentence was revised to read: The Private Duty Nursing Prior Authorization – Request for Services form (MSA-0732) ...
	8/1/2011	Private Duty Nursing	1.1 Definition of PDN (new subsection; following subsections re-numbered)	New subsection text reads: Private Duty Nursing is defined as nursing services for beneficiaries who require more individual and continuous care, in contrast to part-time or intermittent care, than is available under the home health benefit. These services are provided by a registered nurse (RN), or licensed practical nurse (LPN) under the supervision of an RN, and must be ordered by the beneficiary's physician. Beneficiaries requiring PDN must demonstrate a need for continuous skilled nursing services, rather than a need for intermittent skilled nursing, personal care, and/or Home Help services. The terms "continuous" and "skilled nursing" are further defined in the Medical Criteria subsection for beneficiaries under age 21.
			1.3 Prior Authorization	In the 2nd paragraph, the 1st sentence was revised to read: The Private Duty Nursing Prior Authorization – Request for Services form (MSA-0732) must be submitted when requesting PDN for persons with Medicaid coverage before services can begin and at regular intervals thereafter if continued services are determined to be necessary. The following text was inserted after the 2nd paragraph:

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				The MSA-0732 must be submitted every time services are requested for the following situations: • for initial services when the beneficiary has never received PDN services under Medicaid, such as following a hospitalization or when there is an increase in severity of an acute or chronic condition; • for continuation of services beyond the end date of the current authorization period (renewal); • for an increase in services; or • for a decrease in services. Following receipt and review of the MSA-0732 and the required documentation by the Program Review Division, a Notice of Authorization is sent to the PDN provider and beneficiary or primary caregiver, either approving or denying services, or requesting additional information. The provider must maintain this notice in the beneficiary's medical record. For services that are approved, the Notice of Authorization will contain the prior authorization number and approved authorization dates. It is important to include this PA number on every claim and in all other communications to the Program Review Division. If a beneficiary receiving PDN continues to require the services after the initial authorization period, a new MSA-0732 must be submitted along with the required documentation supporting the continued need for PDN. This request must be received by the Program Review Division no less than 15 business days prior to the end of the current authorization period. Failure to do so may result in a delay of authorization for continued services which, in turn, may result in delayed or no payment for services rendered without authorization. The length of each subsequent authorization period will be determined by the Program Review Division and will be specific to each beneficiary based on several factors, including the beneficiary's medical needs and family situation.

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				If during an authorization period a beneficiary's condition changes warranting an increase or decrease in the number of approved hours or a discontinuation of services, the provider must report the change to the Program Review Division. (Refer to the Directory Appendix for contact information.) It is important that the provider report all changes as soon as they occur, as well as properly updating the plan of care. The request to increase or decrease hours must be accompanied by an updated and signed POC; and documentation from the attending physician addressing the medical need, if the request is for an increase in PDN hours. Often the request to begin services will be submitted by a PDN agency or individual PDN; however, a person other than the PDN provider (such as the hospital discharge planner, CSHCS case manager, physician, or physician's staff person) may submit the MSA-0732. When this is the case, the person submitting the request must do so in consultation with the PDN agency or individual PDN who will be assuming responsibility for the care of the beneficiary. If services are requested for more than one beneficiary in the home, a separate MSA-0732 must be completed for each beneficiary. The 3rd paragraph was deleted; the 4th paragraph remains.
			1.3.A. Documentation Requirements (new subsection)	New subsection text reads: The following documentation is required for all PA requests for PDN services and must accompany the MSA-0732: • Most recent signed and dated nursing assessment completed by a registered nurse; • Nursing notes for two (2) four-day periods, including one four-day period that reflects the most current medically stable period and another four-day period that reflects the most recent acute episode of illness related to the PDN qualifying diagnosis/condition;

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				• Most recent updated POC signed and dated by the ordering/managing physician that supports the skilled nursing services requested; The POC must include: ➢ Name of beneficiary and Medicaid ID number; ➢ Diagnosis(es)/presenting symptom(s)/condition(s); ➢ Name, address, and telephone number of the ordering/managing physician; ➢ Frequency and duration, if applicable, of skilled nursing visits, and the frequency and types of skilled interventions, assessments, and judgments that pertain to and support the PDN services to be provided and billed; ➢ Identification of technology-based medical equipment, assistive devices, (and/or appliances), durable medical equipment, and supplies; ➢ Other services being provided in the home by community-based entities that may affect the total care needs; ➢ List of medications and pharmaceuticals (prescribed and over-the-counter); ➢ All hospital discharge summaries for admissions related to the PDN qualifying diagnosis/condition within the last authorization period; ➢ Statement of family strengths, capabilities, and support systems available for assisting in the provision of the PDN benefit (for renewals, submit changes only). • Other documentation as requested by MDCH.
			1.3.B. Beneficiary Eligibility (new subsection)	New subsection text reads: Approval of a PA request on the MSA-0732 confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the date of service, MDCH will not reimburse the provider for services provided and billed. To assure payment, the provider must verify beneficiary eligibility monthly at a minimum.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			1.3.C. Retroactive Prior Authorization (new subsection)	New subsection text reads: Services provided before PA is requested will not be covered unless the beneficiary was not Medicaid eligible on the date of service but became eligible retroactively. If the MDCH eligibility information does not demonstrate retroactive eligibility, then the request for retroactive PA will be denied.
			1.5 General Eligibility Requirements	In the 5th bullet point, the last sentence was revised to read: The POC must be updated at least annually or more frequently as needed based on the beneficiary's medical needs.
			1.9 PDN in Conjunction with Home Help or Personal Care Services (new subsection; following subsections re-numbered)	New subsection text reads: If the beneficiary receiving PDN demonstrates a need for personal care or Home Help services in addition to PDN, there must be coordination between the delivery of personal care or Home Help services and the PDN services, as well as documentation in the plan of care (POC) to verify there is no duplication of services.
			2.1 Plan of Care	The 1st paragraph was revised to read: ... participate in developing the POC. The POC identifies and addresses the beneficiary's need for PDN. The POC and the process for developing it ...
		Forms Appendix	MSA-0732	updated with revised (07/11) version

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 11-29	8/1/2011	Maternal Infant Health Program	1.3 Eligibility	Text for "Both Maternal and Infant Services" was revised to read: In cases of multiple births, each infant needs to have a separate risk identifier assessment visit completed and entered into the electronic MIHP database when available. In the case where a foster care mother has two infants in the same home, there also needs to be a separate risk identifier assessment visit done for each infant. These separate risk identifier visits can be billed separately under each individual infant Medicaid identification number (ID). Subsequent professional visits will be billed under each infant ID if the infants are from different families. If the infants are siblings, then the visits will be blended visits. Blended visits can only be billed under one Medicaid ID. An infant case and a maternal case can both be open at the same time. The appropriate risk identifier assessment visit should be completed and entered into the database. If the MIHP is seeing an infant and the mother becomes pregnant, a maternal risk identifier assessment visit should be completed and services started. After the initial risk identifier assessment visit is completed, all professional visits should be blended visits and billed under one Medicaid ID.
			2.9.A. Maternal Services	In the 4th bullet point, text after the 1st sentence was revised to read: • … An MIHP provider may complete and bill an infant risk identifier visit separate from a maternal postpartum professional visit. A maternal postpartum professional visit may be made on the same date of service as the infant risk identifier visit. Providers must document why both visits need to be done on the same date of services. The maternal visit must be a minimum of 30 minutes and be reflected in the professional note. After the risk identifier assessment visit has been completed, all subsequent professional visits should be blended visits.
			Section 3 - Reimbursement	In the 4th paragraph, the 1st sentence was revised to read: … and one Infant Risk Identifier per infant.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 11-22	6/1/11	Hospital Reimbursement Appendix	2.5 Relative Weights	The paragraph following the table was revised to read: The statewide relative weights calculated for the Michigan system utilize Medicaid and Children's Special Health Care Services (CSHCS) FFS and MHP encounter inpatient claims for admissions during two consecutive state fiscal years and hospital specific cost report data drawn from two consecutive cost report years used to establish the relative weights.
			2.6 Episode File	The 14th bullet point was revised to read: • Bring all charges for admissions in the first year of the base period up to the second year charges through application of inflation and weighting factors. In the 15th bullet point, the 5th sub-bullet was revised to read: ➢ The wage adjustor is based on a two-year moving average, with the most recent year weighted 60 percent and the second year weighted 40 percent. In the 16th bullet point, the 2nd sub-bullet point was revised to read: ➢ Data taken from the hospital's cost report for the two fiscal years is weighted as follows: 60 percent for the most recent year and 40 percent for the second year.
			2.7 DRG Price	In the 1st paragraph, the following text was added as a note to the 1st bullet point: Note: Hospitals identified with Medicare Critical Access Hospital (CAH) status as of July 1, 2011 are grouped and paid a single DRG price. The DRG price is the truncated mean of the hospital-specific base prices of all CAHs, adjusted by the rural cost adjustor and budget neutrality. This is the sum of the product of the hospitals' specific base price times discharges divided by the sum of all group discharges. In the event a hospital status changes from prospective payment system (PPS) to CAH status, MDCH recognizes the hospital under CAH status as of the CMS effective date.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			2.7.C. Budget Neutrality Factor	The following text was added after the 2nd sentence: The estimate is based on one year's paid claims, including MHP encounter data with FFS rates applied. The following text was added after the 1st paragraph: Budget neutrality for CAHs is determined as a group, independent of non-CAHs. As of July 2011, there was a one-time $2 million adjustment to overall budget neutrality for non-CAH hospitals to adjust for the adoption of the three-day payment rule. The one-time increase is carried forward into future budget neutrality adjustments.
			2.7.D. Cost-to-Charge Ratio (new subsection; following subsection re-numbered)	New subsection text reads: For payment purposes, a single cost-to-charge ratio is published on the MDCH website. The single cost-to-charge ratio is used for calculating payments paid a percent of charge, cost outliers, and low-day outliers. The ratio is calculated from the averages of FFS and MHP ratios, net of IME.
MSA 11-21	6/01/2011	General Information for Providers	13.4 Non-Payment and Reporting Requirements for Provider Preventable Conditions (PPCs) (new subsection; following subsection re-numbered)	New subsection text reads: In accordance with federal regulations, Michigan Medicaid is prohibited from reimbursing providers for services related to Provider Preventable Conditions (PPCs), as defined below. Providers are required to report the occurrence of PPCs. This policy applies to all services performed on Medicaid beneficiaries, including dual-eligible beneficiaries and those enrolled in Medicaid Health Plans. MDCH will align with Medicare's policy and billing guidelines for all providers impacted by this policy, and adopt CMS' changes.

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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>13.4.A. Categories of Provider Preventable Conditions

(new subsection)</td><td>New subsection text reads:
<table>
<tr><td>Health Care Acquired Conditions (HCAC)</td><td>Applies to inpatient hospital settings and includes, at a minimum, the full list of conditions/secondary diagnosis codes identified by CMS as HCACs when not present on hospital admission.</td></tr>
<tr><td>Other Provider Preventable Conditions (OPPC)</td><td>Applies to conditions occurring in any health care setting that could have reasonably been prevented through the application of evidence based guidelines. Conditions currently identified by CMS include:
wrong surgical or other invasive procedure performed on a patient;
surgical or other invasive surgery performed on the wrong body part; and
surgical or other invasive procedure performed on the wrong patient.</td></tr>
</table></td></tr>
<tr><td></td><td></td><td></td><td>13.4.B. Payment Adjustment and Reporting Requirements for PPCs

(new subsection)</td><td>New subsection text reads:

Any reduction in payment will be limited to the amounts directly identifiable as related to the PPC and the resulting treatment. The beneficiary and/or their family are held harmless and the provider and/or facility/hospital must not bill the Medicaid beneficiary or their family (including co-payment, deductibles or coinsurance) for PPCs.

MDCH will not accept Medicare primary or Medicaid secondary professional or institutional crossover claims resulting in zero liability.

Providers must report the occurrence of a PPC through the appropriate claim(s) type submission process. Providers are referred to the Billing & Reimbursement Chapters of this manual for specific information on reporting requirements and claim submission.</td></tr>
</table>

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Billing & Reimbursement for Institutional Providers	Section 5 - Provider Preventable Conditions (PPCs) 5.1 Reporting and Non-Payment for Provider Preventable Conditions (PPCs) (new section and subsection; following sections and subsections re-numbered)	New subsection text reads: Provider Preventable Conditions (PPCs) addresses both hospital and non-hospital conditions identified by MDCH for non-payment. PPCs are defined as Health Care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). Medicaid providers are required to report the occurrence of a PPC and are prohibited from payment.
			5.2 Health Care Acquired Conditions (HCAC) – Inpatient Hospital (new subsection)	New subsection text reads: MDCH follows Medicare's policy on reporting Present on Admission (POA) indicators on inpatient hospital claims and non-payment for HCACs. Acute care hospitals and Critical Access Hospitals (CAHs) are required to report whether a diagnosis on a Medicaid claim is present on admission. Claims submitted without the required POA indicators are denied. For claims containing secondary diagnoses that are included on Medicare's most recent list of HCACs and for which the condition was not present on admission, the HCAC secondary diagnosis is not used for DRG grouping. That is, the claim is paid as though any secondary diagnoses (HCAC) were not present on the claim. POA is defined as "present" at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered Present on Admission. A POA indicator must be assigned to principal and secondary diagnoses. Providers should refer to the CMS Medicare website for the most up to date POA reporting instructions and list of HCACs ineligible for payment.

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			5.3 Other Provider Preventable Conditions (OPPCs) - Outpatient (new subsection)	New subsection text reads: Medicaid follows the Medicare guidelines and national coverage determinations (NCDs), including the list of HAC conditions, diagnosis codes and OPPCs. Conditions currently identified by CMS include: • wrong surgical or other invasive procedure performed on a patient; • surgical or other invasive surgery performed on the wrong body part; and • surgical or other invasive procedure performed on the wrong patient.
			5.4 Non-Payment and Reporting Requirements Provider Preventable Conditions (PPCs) - Inpatient (new subsection)	New subsection text reads: MDCH follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NCDs service/procedure (as a PPC) is reported. If covered services/procedures are also provided during the same stay, MDCH follows Medicare's billing guidelines requiring hospitals submit two claims: one claim with covered services, and the other claim with the non-covered services/procedures as a non-pay claim. Inpatient hospitals must appropriately report one of the designated ICD-9-CM diagnosis codes for the PPC on the no-pay TOB claim.
			5.5 Non-Payment and Reporting Requirements Other Provider Preventable Conditions (PPCs) - Outpatient (new subsection)	New subsection text reads: Medicaid follows the Medicare guidelines and NCDs, including the list of HAC conditions, diagnosis codes and OPPCs. Outpatient providers must use the appropriate claim format, TOB and follow the applicable NCD/modifier(s) to all lines related to the surgery(s).

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

<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>Billing & Reimbursement for Professionals</td><td>6.17 Provider Preventable Conditions (PPCs)

(new subsection; following subsections re-numbered)</td><td>New subsection text reads:
<table><tr><td>Coding</td><td>Providers must refer to the current CPT and HCPCS code books for the full descriptions of the national procedure codes and for additional explanatory information that may affect billing.</td></tr><tr><td>Modifiers</td><td>Every PPC service must have an appropriate HCPCS modifier reported on the service line. (Refer to the Modifiers section of this chapter for additional information.)</td></tr></table></td></tr>
<tr><td></td><td></td><td></td><td>7.11 Provider Preventable Conditions (PPCs)

(new subsection; following subsections re-numbered)</td><td>New subsection text reads:

Any service reported to Medicaid for a PPC that has been identified for non-payment must be submitted with the appropriate modifier on the service line.
<table><tr><th>Modifier</th><th>Description</th><th>Special Instructions</th></tr><tr><td>PA</td><td>Surgery Wrong Body Part</td><td>Use this modifier to report that service is for surgery on wrong body part</td></tr><tr><td>PB</td><td>Surgery Wrong Patient</td><td>Use this modifier to report that service is for surgery on wrong patient</td></tr><tr><td>PC</td><td>Wrong Surgery on Patient</td><td>Use this modifier to report that service is for wrong surgery on patient</td></tr></table></td></tr>
<tr><td></td><td></td><td>Acronym Appendix</td><td></td><td>Addition of:

HCAC Health Care Acquired Condition
OPPC Other Provider Preventable Condition
POA Present on Admission
PPC Provider Preventable Condition</td></tr>
<tr><td>MSA 11-19</td><td>06/01/2011</td><td>Mental Health/ Substance Abuse</td><td>Section 7 - Home-Based Services</td><td>Section 7 was revised in its entirety.</td></tr>
</table>

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Medicaid Provider Manual October 2011 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 11-17	5/10/2011	Medical Supplier	1.7.H. Reimbursement Amounts	In the 1st paragraph, text after the 2nd sentence was revised to read: For items that do not have established fee screens or are custom fabricated, the reimbursement will be acquisition cost plus 17% over cost. The provider must provide a manufacturer's invoice that states the acquisition cost for the service on the PA request form. Manufacturer quotes or dealer list prices are not accepted as documentation of cost. Modified manufacturer invoices will not be accepted. If the manufacturer's actual invoice is not included, medical review will assign a penny screen to the code until the actual invoice is received. If the provider is requesting reimbursement for labor, ...
			1.8.C. Repairs and Replacement Parts	In the 6th paragraph, the 5th sentence was revised to read: The provider must provide a manufacturer's invoice that states the acquisition cost for the service with the PA request form.
		Glossary	Acquisition Costs	Definition revised to read: The manufacturer's invoice price, minus primary discount. Includes actual shipping costs.
MSA 11-12	3/1/2011	Local Health Departments	2.5 Medicaid Health Plan Services	The following text was added after the 2nd paragraph: LHDs must bill the MHP directly for immunizations provided to beneficiaries enrolled in managed care. Any claims billed to the Community Health Automated Medicaid Processing System (CHAMPS) for MHP members will be denied.

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Supplemental Bulletin List

The following is a list of Medicaid policy bulletins issued on and after January 1, 2011 that supplement the online version of the Medicaid Provider Manual. The list is updated as additional policy bulletins are issued. The updated list is posted on the MDCH website along with the Medicaid Provider Manual.

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

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	COMMENTS
9/1/2011	MSA 11-42	Sanctioned Provider Update	All Providers	
9/1/2011	MSA 11-41	***Healthy Kids Dental*** Contract Expansion	Dentists and Dental Clinics	
9/1/2011	MSA 11-40	Licensure Requirements for Occupational Therapists (OTs), Occupational Therapy Assistants (OTAs), and Physical Therapy Assistants (PTAs)	Outpatient Hospitals, Outpatient Rehabilitation Facilities, Practitioners, School Based Services, Home Health, Medical Suppliers	
9/1/2011	MSA 11-39	Updates to the Medicaid Provider Manual; Database Update; Maternal Infant Health Program; Average Wholesale Price (AWP); HIPAA 5010 Update	All Providers	Updates to the Medicaid Provider Manual were incorporated into the Medicaid Provider Manual for the October 2011 update. Remaining subjects are for informational purposes only and will not be incorporated into the Medicaid Provider Manual.
9/1/2011	MSA 11-38	Home Help Program Instrumental Activities of Daily Living Services	Home Help Agency and Individual Providers	Bulletin will be incorporated into the Department of Human Services (DHS) Adult Services Manual.

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DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	COMMENTS
9/1/2011	MSA 11-36	Health Insurance Portability and Accountability Act (HIPAA) 5010/National Council for Prescription Drug Programs (NCPDP) D.0 Implementation and Business-to-Business (B2B) Testing	All Providers	
9/1/2011	MSA 11-35	Limits for Dental Radiographs	Dentists	
8/1/2011	MSA 11-34	Data Collection for Hospital Electronic Health Records (EHR) Incentive Program	Hospitals	Bulletin is for informational purposes only; will not be incorporated into the Medicaid Provider Manual.
07/01/2011	MSA 11-30	Data Collection for Hospital Electronic Health Records (EHR) Incentive Program	Hospitals	Bulletin is for informational purposes only; will not be incorporated into the Medicaid Provider Manual.
07/01/2011	MSA 11-28	Healthcare Common Procedure Coding System (HCPCS) Code Updates	Practitioners, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, Hospitals, Ambulatory Surgical Centers, Local Health Departments, Medicaid Health Plans, County Health Plans, and Mental Health and Substance Abuse	Information regarding fee screens and coverage parameters is located in the appropriate database posted on the Michigan Department of Community Health (MDCH) website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

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DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	COMMENTS
07/01/2011	MSA 11-27	MI Choice Policy Chapter	Medicaid Home and Community Based Services Waiver for the Elderly and Disabled (MI Choice), Nursing Facilities, County Medical Care Facilities, Hospital Long Term Care Units, Hospital Swing Beds, Ventilator-Dependent Care Units, Centers for Independent Living	
07/01/2011	MSA 11-26	Inpatient Hospital Payment Reduction	Hospitals	Bulletin is for informational purposes only; will not be incorporated into the Medicaid Provider Manual.
06/16/2011	MSA 11-25	New Taxonomy Reporting Requirements	Family Planning Clinics, Federally Qualified Health Centers (FQHCs), Local Health Departments (LHDs), Laboratory, Maternal Infant Health Program (MIHP)	
06/01/2011	MSA 11-24	Sanctioned Providers Update	All Providers	Information incorporated into the Sanctioned Providers List maintained on the MDCH website at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> List of Sanctioned Providers.
06/01/2011	MSA 11-23	Payment Adjustments for Practitioner Services Provided Through Designated Public Entities	Practitioners, Dentists, Hospitals (Inpatient, Outpatient), Vision	
06/01/2011	MSA 11-20	Medicaid Estate Recovery	Bridges Eligibility Manual Holders	Information applies to Bridges Eligibility Manual; will not be incorporated into the Medicaid Provider Manual.

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Supplemental Bulletin List

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	COMMENTS
06/01/2011	MSA 11-14	Medicaid Coverage of Tobacco Cessation for Pregnant Women	All Providers	Bulletin is for informational purposes only; will not be incorporated into the Medicaid Provider Manual.
03/01/2011	MSA 11-11	Concurrent Hospice and Curative Care for Children	Hospice, Medicaid Health Plans, MIChild Health Plans, MIChild Manual Holders, Local Health Departments, MIChild Administrative Contractor (MAXIMUS), Department of Human Services Central Office, Tribal Health Centers, Federally Qualified Health Centers	Bulletin is for informational purposes only; will not be incorporated into the Medicaid Provider Manual.
03/01/2011	MSA 11-10	Countable Assets for Medicaid	Bridges Eligibility Manual holders	Information applies to Bridges Eligibility Manual; will not be incorporated into the Medicaid Provider Manual.
03/01/2011	MSA 11-09	Clarification to Bulletin MSA 10-53	Hospitals, Physicians, Medical Suppliers, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers	Bulletin is for clarification purposes only; will not be incorporated into the Medicaid Provider Manual.
01/31/2011	MSA 11-03	Corrections to Bulletin MSA 10-65	All Providers	Information regarding fee screens and coverage parameters is located in the appropriate database posted on the Michigan Department of Community Health (MDCH) website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.
01/01/2011	MSA 11-02	Additional Codes Payable to Family Planning Clinics	Family Planning Clinics	Code information is available on the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Family Planning.