MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number:	MSA 12-06
Distribution:	All Providers
Issued:	March 1, 2012
Subject:	Updates to the Medicaid Provider Manual; ICD-10 Coding Implementation
Effective:	April 1, 2012
Programs Affected:	Medicaid, Adult Benefits Waiver, Children's Special Health Care Services, Children's Waiver, Maternity Outpatient Medical Services, MIChoice Waiver, *Plan First!*

Updates to the Medicaid Provider Manual

The Michigan Department of Community Health (MDCH) has completed the April 2012 update of the online version of the Medicaid Provider Manual. Attachments to this bulletin describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change.

If changes were made in a chapter, a note will appear in the affected section/subsection title of that chapter's table of contents. If both technical and bulletin incorporation changes apply to the section/subsection, color coding will be limited to reflect a bulletin-related change.

ICD-10 Coding Implementation

On January 16, 2009, Health and Human Services (HHS) published final regulations (45 CFR 162.1002) that set a compliance date of October 1, 2013 for implementation of ICD-10-CM and ICD-10-PCS. Recently, HHS announced that they will initiate a process to postpone the original compliance date by which certain health care entities must comply. As further guidance is finalized and released, it will be shared accordingly.

The implementation of ICD-10 continues to be a high priority for the MDCH Medical Services Administration (MSA) as the current ICD-9 code sets are outdated due to their limited ability to accommodate new procedures and diagnoses. This requirement has wide-reaching impact for all health care providers, health plans, and State Medicaid agencies. Therefore, the MSA project plan for ICD-10 will proceed as if there is no delay in the compliance date. To accomplish this large complex initiative, MSA has established a cross-functional project team to identify, address, and test the changes needed in policy, systems, and business processes.

The implementation of ICD-10 is a sweeping change far beyond the annual code updates of the past. It is designed to modernize terminology; allow for new conditions, treatments, and technology/devise; and to increase the information available for public health, bio-surveillance, quality measurement, and tracking fraud and abuse.

Additional information will be posted on the MDCH website at www.michigan.gov/5010icd10 .

Manual Maintenance

If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy and Forms, this bulletin and those referenced in this bulletin may be discarded. If using a CD version of the Medicaid Provider Manual, providers should retain all quarterly manual update bulletins, with their attachments, in addition to bulletins issued since the version date of the CD. Providers are encouraged to use the Michigan Medicaid Provider Manual on the MDCH website; the online version of the manual is updated on a quarterly basis.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
Medical Services Administration

Michigan Department of Community Health

Medicaid Provider Manual April 2012 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	8.3 Noncovered Services	The following was added as the 1st paragraph: The items or services listed below are not covered by the Medicaid program: • Acupuncture • Autopsy • Biofeedback • All services or supplies that are not medically necessary • Experimental/investigational drugs, biological agents, procedures, devices or equipment • Routine screening or testing, except as specified for EPSDT Program or by Medicaid policy • Elective cosmetic surgery or procedures • Charges for missed appointments • Infertility services or procedures for males or females, including reversal of sterilizations • Charges for time involved in completing necessary forms, claims, or reports	Information was relocated from the Hospital Chapter with the intent to have subject matter in one location.
General Information for Providers	10.2.D. Reimbursement	The following was added at the end of the 1st paragraph: MDCH reserves the right to set a dollar limit on how much MDCH will reimburse for a Not Otherwise Classified (NOC) code or any manually priced procedure code for a specific range of products.	Clarification

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

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Professionals	7.6.G. Enteral Nutrition	The following was added to the chart: Modifier: U3 Description: Medicaid State Defined Level 3 used with B4087 for low profile ext. Special Instructions: Refer to the MDCH Medical Supplier/DME/Prosthetics and Orthotics Database on the MDCH website for additional information. (Refer to the Directory Appendix for website information.)	Information
Billing & Reimbursement for Professionals	7.14 Surgical Services	In the chart for modifier 52 under Special Instructions, the 2nd paragraph was revised to read: Refer to the Maternity Care Services section of this chapter for maternity care component billing instructions.	General update
Dental	2.3 Toll-Free Phone Number	The subsection was re-named to read "CHAMPS Website." The 1st paragraph was revised to read: Dentists should refer to the CHAMPS website for information on previous PA requests, status of current requests, and to update PA requests. To assist in the efficient use of this service, providers should have the beneficiary's file, including all necessary data and information, available when making an inquiry.	General update
Dental	2.4 Approved Prior Authorization Requests	In the 4th paragraph, the 1st and 2nd sentences were revised to read: ... all treatment authorized must be completed within 365 days from the date of authorization. If treatment is not completed within the 365 days, the PA request must be updated ...	General update

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital	Section 4 - Noncovered Services	Information was re-located to the General Information for Providers chapter; Noncovered Services subsection. Section 4 - Noncovered Services was deleted and the following sections were re-numbered.	Combine subject information into one location.
Hospital	6.10 Diapers for Home Use	In the 2nd paragraph, the 5th bullet point ("For CSHCS beneficiaries, the prescription must relate to the CSHCS qualifying diagnosis") was removed.	Obsolete information
Hospital Reimbursement Appendix	Section 11 – Settlements	The paragraph was revised to read: Settlement is based upon processed non-zero dollar Medicaid liability invoices for services rendered to Medicaid beneficiaries during the cost report period.	Clarification
Maternal Infant Health Program	1.3 Eligibility	Information for "Both Maternal and Infant Services" was revised to read: An infant case and a maternal case can both be open at the same time in some incidences. If the MIHP is seeing an infant and the mother becomes pregnant, a maternal risk identifier assessment visit can be completed and billed as such. After this initial risk identifier assessment visit is completed, all subsequent professional visits for that family should be blended visits and billed under one Medicaid ID. The program is based on the family dyad, and both the infant and parent are to be assessed at each visit and billed as "blended visits" under either the parent's or the infant's Medicaid ID.	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Maternal Infant Health Program	2.3 Multiple Births	Subsection text was revised to read: In cases of multiple births, each infant should have a separate risk identifier visit completed. This also applies to infants in foster care where there are two infants in the same home. These separate risk identifier visits can be billed separately under each individual infant Medicaid identification number. Subsequent professional visits should be billed under each infant ID if the infants are from different families, such as with foster care families. If the infants are siblings, the visits should be "blended visits" and billed under one Medicaid ID only. The risk identifier visit and up to nine professional visits can be made to the family. A physician order is needed if more than nine infant visits are needed per family.	Clarification
Medical Supplier	1.7.H. Reimbursement Amounts	The following was added at the end of the 1st paragraph: MDCH reserves the right to set a dollar limit on how much MDCH will reimburse for a NOC code or any manually priced procedure code for a specific range of products.	Clarification
Medical Supplier	1.8.C. Repairs and Replacement Parts	In the 2nd paragraph after the table, reference to code E1340 was revised to read K0739.	Code update
Medical Supplier	2.19 Incontinent Supplies	In the table: • The portion titled "Standards of Coverage (Applicable to All Programs)" was revised to read "Standards of Coverage (Not Applicable to CSHCS Only Beneficiaries)." • The portion titled "Standards of Coverage (Not Applicable to CSHCS Only Beneficiaries)" was revised to read "Standards of Coverage (Applicable to All Programs)."	Correction
Medical Supplier	2.39 Speech Generating Devices	Under "PA Requirements", 5th paragraph (Repairs), reference to code E1340 was revised to read K0739.	Code update

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	9.1 Medicare-Covered Services	In the 1st paragraph, the 2nd sentence (This limitation also applies if the beneficiary is eligible for, but not enrolled in, Medicare.) was removed.	Inaccurate information
Nursing Facility Coverages	10.3 Ancillary Services	In the 5th paragraph, the 3rd sentence (Some nursing facilities are exempt from billing certain ancillary services (e.g., only a Hospital Long Term Care Unit can bill for pharmacy).) was removed.	Correction; Hospital Long Term Care Units cannot bill Medicaid directly for pharmaceuticals. (Refer to Pharmacy subsection.)
Nursing Facility Coverages	10.8.A. Standard Equipment	In the 1st paragraph, the 3rd and 4th sentences were removed. (Deleted: The nursing facility costs of these items may be reported as routine costs on the cost report. The cost of items rented for use by a resident covered under a Medicare Part A stay are not allowable routine costs and must not be reported on the cost report.)	Inaccurate information
Directory Appendix	Appeals	Under "Appeals (Provider)", the following phone number was added: 877-833-0870	Information

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 11-07	03/01/2011	Practitioner	13.2 Breast Reconstruction Surgery (new subsection; following subsections re-numbered)	New subsection text reads: Medicaid covers breast reconstruction surgery following the diagnosis and treatment of breast cancer. Covered services include procedures related to the affected and the contralateral unaffected breast following a medically necessary mastectomy. The prior authorization requirements for these specified breast reconstructive procedure codes are waived when billed with appropriate ICD-9-CM breast cancer diagnosis codes. The specified CPT codes subject to this PA waiver are identified in the Comments section of the MDCH Practitioner and Medical Clinic Database located on the MDCH website. (Refer to the Directory Appendix for website information.)
MSA 11-49	12/1/2011	Billing & Reimbursement for Professionals	6.23 Vision	Under "Nonroutine Eye Examination", the word "symptoms" was revised to read "conditions." Under "Low Vision Services", text was revised to read: When billing for low vision services, the low vision diagnosis must be designated as the primary diagnosis code on the claim service line. Covered low vision diagnosis codes are listed in the MDCH Vision Services Database on the MDCH website. (Refer to the Directory Appendix for website information.)
		Children's Special Health Care Services	Table of Contents page	The textbox was removed as information is not applicable to the Children's Special Health Care Services (CSHCS) program.
		Federally Qualified Health Centers	Table of Contents page	The textbox was revised to read: As required by Executive Order 2009-22, effective for dates of service on and after 07/01/2009, Chiropractic and Vision services (routine eye exams, refractions, eyeglasses, contact lenses, and other vision supplies and associated services) are no longer payable for beneficiaries age 21 and older. Eye exams and other vision services related to eye injury or eye disease will be covered.

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				Per Public Act 187 of 2010, effective for dates of service on and after 10/01/2010, low-vision services (including low-vision eyeglasses, contact lenses, optical devices, and related low-vision services) are payable for beneficiaries age 21 and older. Covered low-vision diagnosis codes are listed in the MDCH Vision Services Database on the MDCH website.
		Rural Health Clinics	Table of Contents page	The textbox was revised to read: As required by Executive Order 2009-22, effective for dates of service on and after 07/01/2009, Chiropractic and Vision services (routine eye exams, refractions, eyeglasses, contact lenses, and other vision supplies and associated services) are no longer payable for beneficiaries age 21 and older. Eye exams and other vision services related to eye injury or eye disease will be covered. Per Public Act 187 of 2010, effective for dates of service on and after 10/01/2010, low-vision services (including low-vision eyeglasses, contact lenses, optical devices, and related low-vision services) are payable for beneficiaries age 21 and older. Covered low-vision diagnosis codes are listed in the MDCH Vision Services Database on the MDCH website.
		Vision	Table of Contents page	The textbox was revised to read: As required by Executive Order 2009-22, effective for dates of service on and after 07/01/2009, vision services (routine eye exams, refractions, eyeglasses, contact lenses, and other vision supplies and associated services) are no longer payable for beneficiaries age 21 and older. Eye exams and other vision services related to eye injury or eye disease will be covered. Per Public Act 187 of 2010, effective for dates of service on and after 10/01/2010, low-vision services (including low-vision eyeglasses, contact lenses, optical devices, and related low-vision services) are payable for beneficiaries age 21 and older. Covered low-vision diagnosis codes are listed in the MDCH Vision Services Database on the MDCH website.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Vision	3.1 Diagnostic Services	In the table under "Eye Examinations", in the 2nd bullet point, the word "symptoms" was revised to read "conditions."
		Vision	3.4.A. Lenses	In the table under "Polycarbonate Lenses", text was revised to read: For beneficiaries age 21 and over, polycarbonate lenses are a Medicaid benefit and do not require PA when diopter criteria are met and the lenses are inserted into a safety frame marked "Z 87" or "Z 87-2." For beneficiaries under age 21, polycarbonate lenses may be inserted into any covered Medicaid frame and do not require PA.
MSA 11-50	12/01/2011	Practitioner Reimbursement Appendix	1.3 Injectables	The following text was added as a 2nd paragraph: Modified methodology pricing places certain lower cost injectable drugs in classes with therapeutic alternatives at the maximum allowable cost. Utilization of lower cost alternative agents within a therapeutic class will have increased reimbursement over current Average Sale Price (ASP) rates, with margins greater than or equal to higher cost agents within the same therapeutic class. Refer to the Physician Administered Drugs and Biologicals Database on the MDCH website for additional information. (Refer to the Directory Appendix for website information.)
MSA 11-52	12/01/2011	Hospital Reimbursement Appendix	2.9.A. Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units	The 1st paragraph was revised to read: The per diem prices calculated for the Michigan Medicaid system utilize Medicaid and CSHCS FFS and MHP encounter inpatient claims for admissions during two consecutive state fiscal years. Hospital specific cost report data is drawn from two consecutive cost report years. In the 7th paragraph, 3rd 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 first year and 40 percent for the second year.

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MSA 11-56	12/22/2011	Billing & Reimbursement for Professionals	6.1 General Information	The following subject and text was added to the chart: Bundled Codes MDCH follows Medicare guidelines for bundled services. CPT procedure codes with a CMS status indicator of "B" indicate that payment for the covered service is always bundled into payment for other related services not specified. These bundled codes do not receive separate reimbursement. Status code indicators may be found in the RVU file on the CMS website. (Refer to the Directory Appendix for website information.)
MSA 11-55	12/29/2011	Pharmacy	5.3 Documentation Requirements	The last sentence of the paragraph was revised to read: Regardless of the format used, the associated documentation must be retained electronically or otherwise for a period of seven years, or longer if specified by law.
		Pharmacy	5.3.A. Non-controlled Electronically Transmitted Prescriptions (new subsection)	New subsection text reads: If a prescription is created, signed, transmitted and received electronically, all records related to that prescription must be retained electronically. Records must be retained electronically for a period of seven years, or longer if specified by law. Records must be made available within 72 hours or as requested. The electronically transmitted prescription must include all of the following information: • The name, address, and telephone number of the prescriber; • The full name of the patient for whom the prescription is issued; • An electronic signature or other identifier that specifically identifies and authenticates the prescriber;

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				• The time and date of the transmission; • The identity of the pharmacy intended to receive the transmission; and • Any other information required by the federal act or state law. The electronic equipment or system utilized in the transmission and communication of prescriptions must provide adequate confidentiality safeguards and be maintained to protect patient confidentiality as required under any applicable federal and state law and to ensure against unauthorized access. The electronic transmission of a prescription must be communicated in a retrievable, recognizable form acceptable to the intended recipient. The electronic form utilized in the transmission of a prescription must not include "dispense as written" or "d.a.w." as the default setting. Prior to dispensing a prescription that is electronically transmitted, the pharmacist must exercise professional judgment regarding the accuracy, validity, and authenticity of the transmitted prescription. An electronically transmitted prescription that meets the above requirements is the original prescription.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 11-58	12/29/2011	Dental	8.1 Covered Services	The 3rd paragraph was revised to read: Beneficiaries under age 21 who are dually-enrolled in Medicaid and Children's Special Health Care Services (CSHCS) and reside in the selected ***Healthy Kids Dental*** counties receive their Medicaid dental benefits through ***Healthy Kids Dental***. Dually-enrolled Medicaid and CSHCS beneficiaries who reside in a county that is **not** listed as part of the ***Healthy Kids Dental*** contract continue to receive dental benefits through Medicaid. If the beneficiary's CSHCS diagnosis qualifies for CSHCS specialty dental services (e.g., orthodontics), the specialty dental services are administered through MDCH and are not part of the ***Healthy Kids Dental*** benefit plan. The specialty provider must be a CSHCS approved provider listed on the beneficiary's file, and must follow the coverage requirements and claims procedures for specialty dentistry described in the Dental Chapter and the Billing & Reimbursement for Dental Providers Chapter.
		Dental	9.1 Coverage and Service Area Information	In the 1st paragraph, the 1st sentence was revised to read "... in 65 counties." In the 2nd paragraph, the following counties were added to the chart: Mason, Muskegon, Newaygo, Oceana
		Tribal Health Centers	3.2 Dental Coverages and Limitations	In the 3rd paragraph, the 1st sentence was revised to read "... by a contractor in 65 Michigan counties."
MSA 12-01	01/19/2012	Billing & Reimbursement for Institutional Providers	8.16 Reporting Medicare on the Medicaid Nursing Facility Claim (new subsection; following subsection re-numbered)	New subsection text reads: When reporting Medicare, nursing facilities must bill as outlined below. • **Covered Days** ➢ Covered days must be reported using Value Code 80.

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				➢ Covered days are the days in which Medicare approves payment for the beneficiary's skilled care. Covered days must be reported when the primary insurance makes a payment. • **Non-Covered Days** ➢ Non-covered days must be reported using Value Code 81. ➢ Non-covered days are the days not covered by Medicare due to Medicare being exhausted or the beneficiary no longer requiring skilled care. Non-covered days must be reported in order to receive the proper Medicaid provider rate payment. ➢ When Medicare non-covered days are reported because Medicare benefits are exhausted, facilities must report Occurrence Code A3 and the date benefits were exhausted, along with Claim Adjustment Reason Code (CARC) 96 (Non-Covered Charges) or 119 (Benefit Maximum for the Time Period has been Reached). ➢ When Medicare non-covered days are reported because Medicare active care ended, facilities must report Occurrence Code 22 and the corresponding date Medicare active care ended, along with CARC 96 or 119. • **Coinsurance Days** ➢ Medicare coinsurance days must be reported using Value Code 82. ➢ Coinsurance days are the days in which the primary payer (Medicare or Medicare Advantage Plan) applies a portion of the approved amount to coinsurance. Coinsurance days must be reported in order to receive the proper coinsurance rate payment.

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				➢ When reporting Value Code 82, Occurrence Span Code 70 (Qualifying Stay Dates for SNF) and corresponding from/through dates (at least a three-day inpatient hospital stay which qualifies the resident for Medicare payment of SNF services) must also be reported. ➢ Facilities billing for beneficiaries in a Medicare Advantage Plan must report CARC 2, and this must equal the Medicare Advantage Plan coinsurance rate times the number of coinsurance days. Facilities using CARC 2 must report it with the amount equal to the coinsurance rate times the number of coinsurance days reported. ➢ Medicare Advantage Plan coinsurance rates vary and do not always equal the Medicare Part A coinsurance rate. Providers must verify the beneficiary's Medicare Advantage Plan coinsurance rate prior to billing Medicaid. • **Prior Stay Date** ➢ If a SNF or nursing facility stay ended within 60 days of the SNF admission, Occurrence Span Code 78 and the from/through dates must be reported along with Occurrence Span Code 70 and the from/through dates. • **Nursing Facilities with Medicaid-Only Certified Beds Not Billing Medicare** ➢ For nursing facilities with Medicaid-only certified beds not billing Medicare, claims submitted directly to Medicaid must be billed as outlined above. For example, for beneficiaries with Medicare coverage based on Medicaid's TPL file, covered days must be left blank if Medicare is not covering the service or benefits have exhausted as Medicare is the primary payer. The non-covered day must be completed and it must equal the service units billed for room and board revenue codes and/or leave days revenue codes.

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				The reason Medicare is not covering the service (e.g., benefits exhausted) must also be reported. • **Claim Examples** ➢ Nursing facility claim examples on how to report Medicare and commercial insurance on the Medicaid nursing facility secondary claim can be found on the MDCH website.
MSA 12-04	01/30/2012	Family Planning Waiver	4.2.H. Medicaid Coverage	Subsection text was revised to read: The applicant cannot be covered by Full Medicaid or the Adult Benefits Waiver Program. Women who have Medicaid Deductible (Group 2) eligibility may also qualify for the ***Plan First!*** Family Planning Waiver Program.
MSA 12-02	01/31/2012	Outpatient Therapy	5.1.B. Services to School-Aged Beneficiaries	Addition of a 4th paragraph; text reads: If a school-aged beneficiary receives medically necessary therapy services in both a school setting (as part of an Individualized Education Plan [IEP]) and in an outpatient setting, coordination of therapy between the providers is required. Providers are to maintain documentation of coordination in the beneficiary's file.
		Outpatient Therapy	5.1.F. Prescription Requirements	In the table under "Initiation of Services", 1st paragraph, the 2nd sentence was revised to read: The outpatient setting allows up to 144 units of OT services provided in the initial 12-month treatment period. In the table under "Initiation of Services", 2nd paragraph, the 1st sentence was revised to read: PA is not required for the initial period of skilled therapy for the first 12 consecutive calendar months in the outpatient setting ...

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				In the table under "Requirements of Continued Therapy", 1st paragraph, the 1st sentence was revised to read "... beyond the initial 12 months." In the table under "Requirements of Continued Therapy", the 2nd paragraph was revised to read "The OT may request up to 12 consecutive calendar months of ...." In the table under "Requirements of Continued Therapy", a 4th paragraph was added and reads: When a beneficiary completes 144 units of initial therapy and then chooses to change providers for continued therapy, prior authorization for the continued therapy is required.
		Outpatient Therapy	5.1.G. Resuming Therapy	Subsection was deleted. (Obsolete information.)
		Outpatient Therapy	5.2.B. Services to School-Aged Beneficiaries	A 3rd paragraph was added and reads: If a school-aged beneficiary receives medically necessary therapy services in both a school setting (as part of an Individualized Education Plan [IEP]) and in an outpatient setting, coordination of therapy between the providers is required. Providers are to maintain documentation of coordination in the beneficiary's file.
		Outpatient Therapy	5.2.F. Prescription Requirements	In the table under "Initiation of Services", the 2nd paragraph was revised to read "...may be provided up to 144 times in 12 months in the outpatient setting." In the table under "Initiation of Services", the 4th paragraph was revised to read "... for the initial period of skilled therapy the first 12 consecutive calendar months in the outpatient setting ...."

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				In the table under "Continued Active Treatment", 1st paragraph, the 1st sentence was revised to read "... beyond the initial 12 months." In the table under "Continued Active Treatment", a 3rd paragraph was added and reads: When a beneficiary completes 144 units of initial therapy and then chooses to change providers for continued therapy, prior authorization for the continued therapy is required.
		Outpatient Therapy	5.2.H. Resuming Therapy	Subsection was deleted. (Obsolete information.)
		Outpatient Therapy	5.3.B. Services to School-Aged Beneficiaries	A 3rd paragraph was added and reads: If a school-aged beneficiary receives medically necessary therapy services in both a school setting (as part of an Individualized Education Plan [IEP]) and in an outpatient setting, coordination of therapy between the providers is required. Providers are to maintain documentation of coordination in the beneficiary's file.
		Outpatient Therapy	5.3.C. Physician Referral for Speech Therapy	In the table under "Initiation of Services", 2nd paragraph, the 1st sentence was revised to read "... during the 12 consecutive calendar months in the outpatient setting." In the table under "Continued Active Treatment", 1st paragraph, the 1st sentence was revised to read "... for therapy beyond the initial 12 months." In the table under "Continued Active Treatment", the 2nd paragraph was revised to read "The SLP may request up to 12 consecutive calendar months of continued ...."

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				In the table under "Continued Active Treatment", a 4th paragraph was added and reads: When a beneficiary completes 36 visits of initial therapy and then chooses to change providers for continued therapy, prior authorization for the continued therapy is required.
		Outpatient Therapy	5.3.E. Resuming Therapy	Subsection was deleted. (Obsolete information.) The following subsections were re-numbered.

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Michigan Department of Community Health

Supplemental Bulletin List

January - March 2012

The following is a list of Medicaid policy bulletins that supplement the online version of the Medicaid Provider Manual. The list is updated as additional policy bulletins are issued. NOTE: As stated in MSA Bulletin 09-60 issued December 1, 2009, this list includes only those bulletins which have not been formally incorporated into the Medicaid Provider Manual maintained on the MDCH website. The updated list showing all bulletins for the current calendar year 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
2/1/2012	MSA 12-03	Sanctioned Provider Update	All Providers	A complete list of sanctioned providers is available on the Michigan Department of Community Health (MDCH) website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> List of Sanctioned Providers
12/22/2011	MSA 11-57	Outpatient Prospective Payment System and Ambulatory Surgical Center Reduction Factor	Hospitals, Ambulatory Surgical Centers (ASCs), Hospital-Owned Ambulance, Comprehensive Outpatient Rehabilitation Facilities, Rehab Agencies, Freestanding Dialysis Centers, Medicaid Health Plans, County Health Plans	Time-sensitive information which does not require incorporation into the Medicaid Provider Manual.
12/22/2011	MSA 11-56	Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Code Updates	All Providers	Providers should refer to the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information for code information.
12/15/2011	MSA 11-51	Graduate Medical Education (GME)	Hospitals, Medicaid Health Plans	Pending approval from Centers for Medicare & Medicaid Services.