MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 15-05

Distribution: All Providers

Issued: March 2, 2015

Subject: Updates to the Medicaid Provider Manual; ICD-10 Project Update; New Coverage of Existing Code; EPSDT/Habilitative Services Update; and Changes to the Michigan Department of Community Health and the Michigan Department of Human Services

Effective: As Indicated

Programs Affected: Medicaid, Healthy Michigan Plan, 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 2015 update of the online version of the Medicaid Provider Manual. The manual will be available April 1, 2015 at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Policy Manual.

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

Please refer to the online version of this bulletin at www.michigan.gov/medicaidproviders >> Policy and Forms to view the attachments that describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change.

ICD-10 Project Update

MDCH continues to offer scenario-based testing for providers to assign ICD-10 diagnosis codes to outpatient medical scenarios that apply to their practice areas. These coding exercises allow providers to assess whether their current clinical systems and procedures provide for adequate data collection to support accurate ICD-10 coding. Scenario-based testing can be accessed on the MDCH website at www.michigan.gov/5010icd10 >> ICD-10 Information >> Testing.

Providers are encouraged to continue communications with software vendors, billing agents and/or service bureaus to ensure systems and procedures will support the use of ICD-10 code sets on all HIPAA transactions by the compliance date of October 1, 2015. Testing of ICD-10 coded transactions remains available through Business-to-Business (B2B) testing with MDCH.

Any questions regarding ICD-10 implementation should be directed to MDCH-ICD-10@michigan.gov. Questions regarding B2B testing of ICD-10 coded transactions should be directed to MDCH-B2B-Testing@michigan.gov. Providers should continue to frequently check the MDCH website at www.michigan.gov/5010icd10 for ICD-10 updates. ICD-10 training availability is posted on the MDCH website at www.michigan.gov/medicaidproviders >>Hot Topics >> Medicaid Provider Training Sessions.

New Coverage of Existing Code

Effective for dates of service on and after January 1, 2015, MDCH will cover Healthcare Common Procedure Coding System (HCPCS) codes V2513 (Contact lens, gas permeable, extended wear, per lens) and V2523 (Contact lens, hydrophilic, extended wear, per lens) for vision providers.

For more information regarding evaluation, prescription and fitting, and replacements for contact lenses, refer to the Vision Chapter of the Medicaid Provider Manual.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Habilitative Services Clarification

Federal EPSDT regulations require coverage of comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment for children under 21 years of age, which includes the coverage of medically necessary habilitative therapy services. This clarification aligns the Medicaid Provider Manual EPSDT Chapter with the Outpatient Therapy Chapter. Limits and prior authorization requirements for habilitative therapy services as described in the Outpatient Therapy Chapter continue to apply.

Changes to the Michigan Department of Community Health and the Michigan Department of Human Services

On February 6, 2015, Governor Rick Snyder signed Executive Order 2015-4, which creates the Michigan Department of Health and Human Services by combining the Department of Community Health and the Department of Human Services. The Medical Services Administration expects the order to take effect on April 10, 2015.

Once in effect, all references to the Department of Community Health will be deemed references to the Department of Health and Human Services. In the coming months, the new department will work to update all references to MDCH on department webpages, forms, brochures, letters, and other publications, including the Medicaid Provider Manual and MAGI Related Eligibility Policy Manual. Providers should continue to use existing MDCH documents while the updates are being completed.

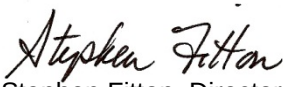
Manual Maintenance

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 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 2015 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	Section 12 – Billing Requirements	Text was revised to read: All claims must be submitted in accordance with the policies, rules, and procedures as stated in the manual and in compliance with applicable coding guidelines and conventions.	Clarification.
Beneficiary Eligibility	2.4 Scope/Coverage Codes	The following statement was added to information for Coverage Codes P and U: (NOTE: TMA-Plus was discontinued as of April 1, 2014.)	Update.
Beneficiary Eligibility	2.6 Special Programs - Beneficiary Identification	The following statement was added to information for Benefit Plan ID: MA-ESO, HK-EXP-ESO, or TMA-PLUS-E: (NOTE: TMA-Plus was discontinued as of April 1, 2014.)	Update.
Billing & Reimbursement for Institutional Providers	7.6.A. Childbirth Education	The 1st bullet point (Use S9442 as the support code.) was deleted.	Information is found in the MDCH Outpatient Prospective Payment System Wrap Around Codes document posted on the MDCH website.
Billing & Reimbursement for Institutional Providers	7.15 Emergency Department Services	Under "Emergency Department Stabilization/Emergency Treatment Services", the 1st bullet point was revised to read: Use the appropriate ED revenue code or combination of codes.	Update.
Billing & Reimbursement for Institutional Providers	8.18 Long-Term Care Insurance	The following text was added as the 2nd sentence: If a beneficiary has long-term care insurance, it must be reported as other insurance on the Medicaid claim.	Information incorporated from Letter L 15-06.

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

Medicaid Provider Manual
April 2015 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	8.19 Monies Received from a Beneficiary and Reported with Value Code 22 (new subsection)	New subsection text reads: When a nursing facility uses Value Code 22 – Surplus to report monies received from a beneficiary, beneficiary's family, or beneficiary's legal representative, the facility must also report these monies to the beneficiary's case worker at the Michigan Department of Human Services (DHS). This must be reported in order for the case worker to evaluate whether or not the money is countable toward the Medicaid asset limit for Medicaid eligibility. When reporting Value Code 22, the facility must report in the "Note" portion of the claim a detailed description of the monies received. The date that the nursing facility contacted the case worker must also be reported in the "Note" portion of the claim.	Information incorporated from Letter L 15-06.
Billing & Reimbursement for Institutional Providers	11.1 Billing Instructions for Hospice Claim Completion	In the 4th bullet point, the 'Description' for Revenue Code 0658 was revised to read 'Other Hospice I (Room & Board)'.	Clarification.
Billing & Reimbursement for Professionals	6.8.B. Days or Units	Under 'Gradient Compression Stockings/Surgical Stockings', 1st paragraph, the 2nd sentence was revised to read: The right (RT) and left (LT) modifiers must be used for these items when reporting HCPCS codes A6530 – A6549.	Update.
Billing & Reimbursement for Professionals	7.13 Surgical Assistance	Under "Special Instructions", the following modifiers were added for Modifiers 80 and 82: XE, XP, XS, XU	Update.

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

<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td>Billing & Reimbursement for Professionals</td><td>7.14 Surgical Services</td><td>The following information was added to the table:

<table>
<tr><th>Modifier</th><th>Description</th><th>Special Instructions</th></tr>
<tr><td>XE</td><td>Separate encounter, a service that is distinct because it occurred during a separate encounter.</td><td>This modifier should only be used to describe separate encounters on the same date of service. May be used in lieu of modifier 59 where this description provides greater specificity.</td></tr>
<tr><td>XP</td><td>Separate Practitioner, A service that is distinct because it was performed by a different practitioner”</td><td>May be used in lieu of modifier 59 where this description provides greater specificity.</td></tr>
<tr><td>XS</td><td>Separate Structure, A service that is distinct because it was performed on a separate organ/structure.</td><td>May be used in lieu of modifier 59 where this description provides greater specificity.</td></tr>
<tr><td>XU</td><td>Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service”</td><td>May be used in lieu of modifier 59 where this description provides greater specificity.</td></tr>
</table></td><td>Update.</td></tr>
<tr><td>Ambulance</td><td>1.2 Common Terms</td><td>The term ‘Cooperating Hospital’ and definition were removed.</td><td>MCL sections as described in the definition have expired/been repealed.</td></tr>
</table>

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Children's Special Health Care Services	2.2 CSHCS Authorized Providers	Text was added to read: Providers will be reimbursed for services provided to a CSHCS client only if authorized by CSHCS to render services to that client. Refer to the MDCH website for a listing of CSHCS authorized providers. (Refer to the Directory Appendix for website information.) To initiate the authorization process, affected providers must contact the CSHCS office in the local health department (LHD) in the client's county of residence. LHD contact information is available on the MDCH website. (Refer to the Directory Appendix for website information.) Providers who do not need authorization to render services to a CSHCS client must be enrolled in the Michigan Medicaid Program. These enrolled providers may render services when ordered or prescribed by a CSHCS-authorized provider and the services are related to the client's CSHCS qualifying diagnosis. The name and NPI of the CSHCS authorized ordering or prescribing provider must be entered in the appropriate field on the claim.	Condensing and clarifying section information.
Children's Special Health Care Services	2.2.A. Providers Requiring Authorization	Subsection was deleted; information was incorporated into 2.2 CSHCS Authorized Providers.	Condensing and clarifying section information.
Children's Special Health Care Services	2.2.B. Providers Not Requiring Authorization	Subsection was deleted; information was incorporated into 2.2 CSHCS Authorized Providers.	Condensing and clarifying section information.
Chiropractor	1.2 Beneficiary Copayment	In the 1st paragraph, the 2nd sentence was deleted. In the 1st paragraph, the following text was added: (Refer to the General Information for Providers Chapter for information on exceptions to Medicaid copayment requirements.)	Clarification.

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

CHAPTER	SECTION	CHANGE	COMMENT
Dental	Section 4 - Place of Service	Text was revised to read: All dental services must be performed in the dental office, public health department dental clinic, dental school, dental hygiene program, mobile facility or Federally Qualified Health Centers (FQHCs). Special situations may necessitate the provision of services at an alternative site such as a hospital/surgical setting or nursing facility.	Re-word for clarification.
Dental	4.1 Hospital Setting	Subsection title was revised to read: Alternative Settings	Re-word for clarification.
Dental	4.1.A. Provision of Care in the Inpatient or Outpatient Setting	Subsection title was revised to read: Inpatient or Outpatient Hospital Setting The 1st paragraph was revised to read: Admission to an inpatient or outpatient hospital setting for any nonemergency dental service is covered for beneficiaries for the following reasons: • The patient has a high-risk medical condition; • The type of procedure requires it to be performed in a hospital setting; or • Other contributing factors could compromise the safety of the patient, such as age, behavioral problems due to mental impairment, etc.	Re-word for clarification
Dental	4.1.B. Services Performed in the Operating Room Setting	Subsection title was revised to read: Surgical Setting	Re-word for clarification
Dental	4.2 Nursing Facility	Subsection was re-numbered as 4.1.C. and title was revised to read: Nursing Facilities	Condensing and clarifying section information.
Dental	4.3 Other Sites	Subsection was re-numbered as 4.1.D.	Condensing and clarifying section information.

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

Medicaid Provider Manual
April 2015 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Dental	8.2.C. Implant Services	In the 6th paragraph, typographical correction: When billing for implant procedures, the date of service is the date of completion.	Spelling error corrected.
Early and Periodic Screening, Diagnosis and Treatment	12.4.A. Environmental Investigations	The 2nd sentence was revised to read: Environmental investigations are covered for the LHD.	Update.
Federally Qualified Health Centers	1.5 Nonenrolled Provider Services	In the 1st paragraph, the 1st sentence was revised to read: Professional services provided by FQHC clinical social workers and clinical psychologists are reimbursed under the PPS or MOA.	Update.
Federally Qualified Health Centers	2.4 Children's Health Insurance Program Services	In the 2nd paragraph, the 2nd sentence was revised to read: For beneficiaries enrolled in a MIChild health plan, the MDCH HCRD will perform an …	Use of acronym. MDCH Hospital and Clinic Reimbursement Division (HCRD) is now defined in subsection 1.3.
Federally Qualified Health Centers	5.6 Prospective Payment Rate for New FQHC Sites	In the 2nd paragraph, 2nd bullet, the 1st sub-bullet point was revised to read: The first year will be inflated to the second fiscal year end using the appropriate MEI factors.	Use of acronym. Medicare Economic Index (MEI) is now defined in subsection 5.5.
Federally Qualified Health Centers	5.7 PPS Medicare Economic Index Adjustment	Subsection was removed.	The information conveyed in this subsection is appropriately addressed in subsection 5.5.

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

Medicaid Provider Manual
April 2015 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hearing Aid Dealers	2.3.D. Payment Rules	The following text was added as the 1st paragraph: Each of the HCPCS procedure codes for CROS systems covers both the transmitter and the receiver. No other hearing aid device procedure code may be billed in addition to the specific CROS code used.	Billing clarification.
Hearing Aid Dealers	2.4.D. Payment Rules	The following text was added as the 1st paragraph: Each of the HCPCS procedure codes for BiCROS systems covers both the transmitter and the receiver/hearing aid. No other hearing aid device procedure code may be billed in addition to the specific BiCROS code used.	Billing clarification.
Medical Suppler	2.8 Commodes	Under 'Standards of Coverage', the 3rd paragraph was revised to read: A shower commode chair may be covered if required to enable the beneficiary to shower independently or with assistance in the home setting and there are no cost effective alternatives.	Clarified language.
Medical Suppler	2.13.A Enteral Nutrition (Administered Orally)	Under 'Documentation', in the 1st paragraph, the 7th (last) bullet point was removed.	Update.
Medical Suppler	2.37 Prosthetics (Lower Extremities)	In the 3rd bullet point, 'L5311' was removed as an example.	Code is no longer active.
Mental Health/ Substance Abuse	17.3.E Family Support and Training	In the 4th paragraph, 3rd bullet point, the 1st sentence was revised to read: Family Psycho-Education (SAMHSA model -- specific information is found in the GUIDE TO FAMILY PSYCHOEDUCATION, Requirements for Certification, Sustainability, and Fidelity) for individuals with serious mental illness and their families.	Provides clarification on FPE program details and requirements.

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

CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	17.3.E. Family Support and Training	In the 4th paragraph, a 5th bullet point was added: Peer support provided by trained youth peer support specialists, one-on-one or in a group, for individuals with serious emotional disturbance who are resolving conflicts, enhancing skills to improve their overall functioning, integrating with community, school and family and/or transitioning into adulthood. This service provides support and assistance for youth in accordance with the goals in their plan of service to assist the youth with community integration, improving family relationships and resolving conflicts, and making a transition to adulthood, including achieving successful independent living options, obtaining employment, and navigating the public human services system.	This service has been an approved service since 2009 and was included in the 2009 B Waiver Renewal. Language defining the service never made it into the Medicaid Manual.
Nursing Facility Coverages	5.1.D.1. Michigan Medicaid Nursing Facility Level of Care Determination	In the 1st paragraph, the 2nd sentence was revised to read: To verify medical/functional eligibility, the nursing facility (i.e., hospital long term care unit, county medical care facility, ventilator dependent unit, hospital swing bed) must complete the online LOCD under the provider's NPI prior to the start of Medicaid reimbursable services. The following textbox was added after the 1st paragraph: Ventilator-Dependent Care Units (VDCUs) and Medicare/Medicaid Crossover Claims: Medicaid-enrolled VDCUs have a distinct National Provider Identifier (NPI) number for Medicaid billing. The number is separate from the "regular" facility NPI number. An LOCD must be completed under the "regular" NPI number for days 1 to 100. For days 101 and forward, the facility must complete an LOCD under the VDCU's distinct NPI number.	Clarification for Vent Unit beneficiaries only. The LOCD must first be completed under the Skilled NPI, followed by the Vent NPI, for beneficiaries residing in a Vent Unit to permit Medicare/Medicaid nursing facility crossover claims.
Outpatient Therapy	5.1 Occupational Therapy	In the 4th paragraph, in the table under "OT is not covered for the following:", 5th bullet point, the following text was added: Note: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative therapy services.	Clarification required to comply with EPSDT regulations.

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

Medicaid Provider Manual
April 2015 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Outpatient Therapy	5.2 Physical Therapy	In the 10th paragraph, the 1st sentence was revised to read: PT is not covered for the following: In the 10th paragraph, 5th bullet point, the following text was added: Note: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative therapy services.	Clarification required to comply with EPSDT regulations.
Outpatient Therapy	5.3 Speech Therapy	In the 4th paragraph, the 1st sentence was revised to read: Speech therapy must relate to a medical diagnosis, and is limited to services for: In the 8th paragraph, the 1st sentence was revised to read: Therapy is not covered: In the 8th paragraph, 6th bullet point, the following text was added: Note: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative therapy services.	Clarification required to comply with EPSDT regulations.
Pharmacy	1.9 Medicare Part D Benefit	In the 2nd paragraph, the 1st and 2nd bullet points were removed.	As of January 1, 2013, benzodiazepines are covered for all Part D medically-accepted indications. As of January 1, 2014, barbiturates are covered for all Part D medically-accepted indications.
Pharmacy	Section 6 - General Noncovered Services	In the 2nd paragraph, the 1st bullet point was revised to read: Agents used for anorexia	Weight loss drugs are covered. PA criteria for weight loss drugs are listed in subsection 8.5.B. Weight Loss of the Pharmacy chapter.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	11.1 Days Supply	In the 1st paragraph, the 2nd sentence was revised to read: MDCH covers up to a 34-day supply for acute medications, and up to a 102-day supply for maintenance medications.	Update/correction.
Pharmacy	13.6.A. Medicaid Copayments	The following text was added after the 1st sentence: A $1 copayment may apply to certain brand name drugs that are preferred.	Clarifies when a brand drug may be preferred and has a lower copayment assigned to it.

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

CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	13.6.A. Medicaid Copayments	In the table for "Copayment Exemptions", the following text was added to "Other Exclusions": Claims for drugs related to the treatment of the following chronic conditions are exempt from copayments for HMP beneficiaries: • Alcohol Use Disorder • Asthma • Chronic Kidney Disease • Chronic Obstructive Pulmonary Disease and Bronchiectasis • Deep Venous Thrombosis (while on anticoagulation)/Pulmonary Embolism (chronic anticoagulation) • Depression • Diabetes • Heart Failure • HIV • Hyperlipidemia • Hypertension • Ischemic Heart Disease • Obesity • Schizophrenia • Stroke/Transient Ischemic Attack • Substance Use Disorder • Tobacco Use Disorder	This incorporates the changes announced through bulletins MSA 14-11 and MSA 14-39 on copayment exemptions for HMP beneficiaries with select chronic conditions.

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

CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	Section 19 – Pharmacy Audit and Documentation	The 1st through 3rd paragraphs were revised to read: MDCH monitors for compliance with Medicaid policy, the Administrative Rules of the Michigan Board of Pharmacy, the Public Health Code, and other applicable federal and state regulations. The following information serves as a general guide for compliance monitoring during post-payment pharmacy reviews and audits. Additional details pertaining to post-payment pharmacy audits can be found on the post-payment auditor's website. (Refer to the Directory Appendix for website and contact information.) Non-compliance, especially continued non-compliance, may result in payment recovery, sanctions, or referral to the Michigan Attorney General's Office.	Clarification.
Pharmacy	Section 19 - Pharmacy Audit and Documentation	In the 3rd paragraph, in the table under "340B Drug Pricing Program", text was revised to read: Billing ingredient costs may not be higher than actual acquisition costs for drugs procured under the 340B Drug Pricing Program.	Adding the words "may not be" clarifies the requirement.
Pharmacy	Section 19 - Pharmacy Audit and Documentation	In the 3rd paragraph, in the table under "Prescription Documentation", the 1st paragraph was revised to read: Original written prescriptions must be executed on tamper resistant prescription pads. If a prescription is created, signed, transmitted, and received electronically, all records related to that prescription must be readily accessible and maintained for seven years. Prescriber medical record documentation may be provided to validate prescriptions. Prescriber affidavits, attestations, and retroactively dated prescriptions will not be accepted for pharmacy documentation. Notation on … The 2nd paragraph was removed.	Updates reflect the current workflow of pharmacies where many prescriptions are received and stored electronically.
Practitioner	17.5 Authorized Practitioners	The 1st paragraph was revised to read: The physician or practitioner at the distant site who is licensed under State law to furnish a covered telemedicine service (as described in the Telemedicine Services subsection) may bill, and receive payment for, the service when it is delivered via a telecommunications system.	Clarification.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	2.1 Individuals with Disabilities Education Act Assessment and IEP/IFSP Development, Review and Revision	Under "Procedure Codes", 2nd paragraph, 20th bullet point, text (code) was revised to read: 92595 - Electroacoustic evaluation for hearing aid; binaural. Editorial note: Codes were placed in numerical/alpha order.	Correction.
School Based Services	2.10 Targeted Case Management Services	Under "Definition", 2nd paragraph, the 2nd bullet point was reformatted as a 3rd sub-bullet point for the 1st bullet point.	Formatting correction.
School Based Services	6.1.C. Interim Payment Process	In the 5th paragraph, text was revised to read: ... issued by the MDCH Hospital and Clinic Reimbursement Division.	Correction.
Special Programs	3.6 Transitional Medical Assistance Plus	The following statement was added: (NOTE: TMA-Plus was discontinued as of April 1, 2014.)	Update.
Special Programs	3.6.A. Eligible Beneficiaries	The following statement was added: (NOTE: TMA-Plus was discontinued as of April 1, 2014.)	Update.
Special Programs	3.6.B. Covered Services	The following statement was added: (NOTE: TMA-Plus was discontinued as of April 1, 2014.)	Update.
Vision	1.1 Beneficiary Eligibility and Copayments	The 3rd paragraph was revised to read: (Refer to the General Information for Providers Chapter of this manual for information on exceptions to Medicaid copayment requirements.)	Clarification.
Acronym Appendix	TMA-Plus	The following statement was added: (NOTE: TMA-Plus was discontinued as of April 1, 2014.)	Update.

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

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Eligibility Verification **Contact/Topic:** CHAMPS Eligibility Inquiry	TMA-Plus was removed from text for "**Information Available/Purpose:**".	Update.
Directory Appendix	Eligibility Verification **Contact/Topic:** Web-DENIS	TMA-Plus was removed from text for "**Information Available/Purpose:**".	Update.
Directory Appendix	Eligibility Verification **Contact/Topic:** Eligibility Verification (out-of-state providers)	TMA-Plus was removed from text for "**Information Available/Purpose:**".	Update.
Directory Appendix	Eligibility Verification **Contact/Topic:** Michigan Public Health Institute	TMA-Plus was removed from text for "**Information Available/Purpose:**".	Update.
Directory Appendix	Provider Resources -- MDCH Healthy Homes Section	The web address was revised to read: http://www.michigan.gov/mdch >> Physical Health & Prevention >> Prevention >> Lead Poisoning >> General Information >> Mission and Staff Under "Information Available/Purpose", the 2nd paragraph was removed.	Update and removal of obsolete information.

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

CHAPTER	SECTION	CHANGE	COMMENT
Forms Appendix	MSA-1755; Medicaid Enrolled Birthing Hospital Agreement for Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation	On the Instructions page, the 5th paragraph was revised to read: The completed MSA-1755 must be mailed or faxed to: … On the Instructions page, the 7th paragraph was removed.	Removal of obsolete and extraneous information.

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

Medicaid Provider Manual
April 2015 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 14-66	12/29/2014	Beneficiary Eligibility	9.1 Enrollment	In the table, under "Excluded Enrollment", the following bullet point was added: • Beneficiaries diagnosed with inborn errors of metabolism that have been authorized for and use metabolic formulas (B4157 and B4162) will receive all of their Medicaid services through the Medicaid Fee-For-Service Program.
		Medicaid Health Plan	1.2 Services Excluded from MHP Coverage but Covered by Medicaid	The following bullet point was added: • Beneficiaries diagnosed with inborn errors of metabolism that have been authorized for and use metabolic formulas (B4157 and B4162) will receive all of their Medicaid services through the Medicaid Fee-For-Service Program.
		Medical Suppliers	2.13.A. Enteral Nutrition (Administered Orally)	Under "Standards of Coverage", 1st section, 1st paragraph, the bullet points were revised to read: • A chronic medical condition exists resulting in nutritional deficiencies, and a three-month trial is required to prevent gastric tube placement; or • Supplementation to regular diet or meal replacement is required, and the beneficiary's weight-to-height ratio has fallen below the fifth percentile on standard growth grids; or • Physician documentation Under "Standards of Coverage", 1st section, a 3rd paragraph was added: For Healthcare Common Procedure Coding System (HCPCS) code B4162, the beneficiary must have a specified inherited disease of metabolism identified by the International Classification of Diseases (ICD). Under "Standards of Coverage", 2nd section, the bullet list was revised to read: • The beneficiary must have a medical condition that requires the unique composition of the formula nutrients that the beneficiary is unable to obtain from food; or • The nutritional composition of the formula represents an integral part of treatment of the specified diagnosis/medical condition; or • The beneficiary ...

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Under “Standards of Coverage”, 2nd section, a 2nd paragraph was added: For Healthcare Common Procedure Coding System (HCPCS) code B4157, the beneficiary must have a specified inherited disease of metabolism identified by the International Classification of Diseases (ICD).
MSA 14-65	12/29/2014	Billing & Reimbursement for Institutional Providers	7.3.B. Multiple Transports Per Beneficiary (new subsection; following subsection was re-numbered)	New subsection text reads: When a beneficiary requires more than one ambulance transport on the same date of service, providers must report: • the appropriate origin and destination modifier with both the base rate and the mileage procedure codes; and • the quantity for each transport base rate as "1" and the quantity for each transport mileage as the number of loaded miles. If a break in service occurs between transports, each transport must be billed as a separate service. A break in service occurs when the ambulance is available to respond to other requests. If there is no break in service between transports, the transport is considered a single run and is described under the Continuous or Round Trip Transports subsection of the Ambulance Chapter of this manual. If a beneficiary requires more than two ambulance transports on the same date of service, additional transports will require PA. Providers should contact the MDCH Program Review Division for PA. When additional transports of an emergent nature are necessary, ambulance providers should secure PA after the transport has been rendered.
		Billing & Reimbursement for Professionals	7.2.B. Multiple Transports Per Beneficiary (new subsection; following subsection was re-numbered)	New subsection text reads: When a beneficiary requires more than one ambulance transport on the same date of service, providers must report: • the appropriate origin and destination modifier with both the base rate and the mileage procedure codes; and • the quantity for each transport base rate as "1" and the quantity for each transport mileage as the number of loaded miles.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				If a break in service occurs between transports, each transport must be billed as a separate service. A break in service occurs when the ambulance is available to respond to other requests. If there is no break in service between transports, the transport is considered a single run and is described under the Continuous or Round Trip Transport subsection of the Ambulance Chapter of this manual. If a beneficiary requires more than two ambulance transports on the same date of service, additional transports will require PA. Providers should contact the MDCH Program Review Division for PA. When additional transports of an emergent nature are necessary, ambulance providers should secure PA after the transport has been rendered.
		Ambulance	3.7 Multiple Transports Per Beneficiary	Subsection text was revised to read: Multiple ambulance transports rendered to the same beneficiary on the same date of service are covered under certain conditions. Information regarding billing and PA for multiple transports for the same beneficiary on the same date of service is contained in the Billing & Reimbursement for Institutional Providers and the Billing & Reimbursement for Professional Chapters of this manual.
MSA 14-64	12/29/2014	MI Choice	3.4 Waiting Lists	The following text was added after the 1st paragraph: Each waiver agency must follow these waiting list removal guidelines when removing an applicant from the MI Choice waiting list. A MI Choice waiver agency may remove an applicant from the MI Choice waiting list if the applicant: • Enrolled in MI Choice; • Enrolled in another community-based service or program; • Was admitted to a nursing facility and is no longer interested in MI Choice; • Died; • Moved out of state; • Was not eligible for MI Choice; • Was no longer interested in or refused MI Choice enrollment; or • Was unable to be contacted by the waiver agency using all of the following methods: ➢ The waiver agency called at least three times with a varied day of week and time of day. ➢ If the waiver agency was able to leave a message, the applicant did not return the call within 10 business days. ➢ The waiver agency sent a letter to the applicant with a deadline to contact the waiver agency within 12 business days, and the applicant either did not respond or mail was returned.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				An Adequate Action Notice must be sent to the applicant no later than the date of removal from the MI Choice waiting list. MI Choice waiver agencies can obtain a template for the Adequate Action Notice on the MDCH website. (Refer to the Directory Appendix for website information.)
		Directory Appendix	MI Choice Waiver Resources	Contact/Topic information was added as follows: Contact/Topic: Waiting List Removal – Adequate Action Notice Web Address: www.michigan.gov/providers >> Providers >> Other Health Care Programs >> MI Choice Information Available/Purpose: MI Choice Waiting List Removal Adequate Action Notice template
MSA 14-63	12/29/2014	Healthy Michigan Plan		The layout of the Healthy Michigan Plan chapter was revised and now reflects the following section/information order: • Section 1 – General Information • Section 2 – Coverage • Section 3 – Healthy Michigan Plan and Healthy Behaviors • Section 4 – Cost Sharing Information • Section 5 – Special Coverage Provisions • Section 6 – Special Behavioral Health Coverage Provisions Section 6 reflects the incorporation of bulletin MSA 14-63.
MSA 14-62	12/29/2014	School Based Services	2.1 Individuals with Disabilities Education Act Assessment and IEP/IFSP Development, Review and Revision	Under "Procedure Codes", 2nd paragraph, the following text was added: • **96127** – Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		School Based Services	2.6 Developmental Testing	Under "Procedure Codes", the following text was added: • **96127** - Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument.
MSA 14-60	12/1/2014	Medical Supplier	2.5 Breast Pump	The subsection title was revised to read "Breast Pumps". Text in the table was re-located to 2.5.A. Hospital-Grade Electric Breast Pump. Subsection text was revised to read: Medicaid covers hospital-grade electric, personal use double electric, and manual breast pumps.
			2.5.A. Hospital-Grade Electric Breast Pump (new subsection)	Text from the table in 2.5 Breast Pump was re-located to this new subsection with the following revisions. Under "Standards of Coverage", the following text was added: • The infant or mother is hospitalized, resulting in a physical separation of the mother and infant; and all of the following applies: ➢ The pump has an adjustable suction pressure at the breast shield during use between 30 mm Hg and 250 mm Hg (suction just at the low or high end is not acceptable); ➢ The pump has a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma; ➢ The pump has an adjustable/varying pumping speed no less than 30 cycles per minute and capable of reaching up to a maximum of 60 cycles per minute; ➢ The pump must be able to operate on a 110-volt household current and be UL listed; ➢ The pump must not weigh over 12 pounds; and ➢ The pump is registered and cleared with the FDA. Under "Documentation", the following text was added: • An order signed by the treating physician or non-physician practitioner. • The International Classification of Diseases (ICD) diagnosis code(s) related to birth or pregnancy. • Documentation of mother's intent to breastfeed.

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

<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></td><td>Documentation must be kept in the beneficiary's file and made available upon request.

Under "Payment Rules", the following text was added:

Rental of the hospital-grade electric breast pump will not be made if a personal use double electric breast pump or a manual breast pump was purchased for the beneficiary within the Standards of Coverage frequency limitations.</td></tr>
<tr><td></td><td></td><td></td><td>2.5.B. Personal Use Double Electric Breast Pump (new subsection)</td><td>New subsection text reads:
<table>
<tr><td>Definition</td><td>A personal use double electric breast pump is defined as a double electric (AC and/or DC) pump, intended for a single user, capable of being used frequently on a daily basis.</td></tr>
<tr><td>Standards of Coverage</td><td>A personal use double electric breast pump may be covered once per five years for a beneficiary when all of the following criteria are met:

• The mother expresses the desire to breastfeed;
• The pump has been registered and cleared by the FDA;
• The pump has a minimum of a one-year manufacturer's warranty;
• The pump has an adjustable suction pressure at the breast shield during use between 30 mm Hg and 250 mm Hg (suction just at the low or high end is not acceptable);
• The pump has a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma;
• The pump has an adjustable/varying pumping speed no less than 30 cycles per minute and capable of reaching up to a maximum of 60 cycles per minute;
• The pump must be able to operate on a 110-volt household current and be UL listed;
• The pump must not weigh over 12 pounds; and
• The pump collection bottle must be bisphenol-A (BPA) and DHEP-free.</td></tr>
<tr><td>Documentation</td><td>Must be less than 30 days old and include all of the following:

• An order signed by the treating physician or non-physician practitioner.
• The International Classification of Diseases (ICD) diagnosis code(s) related to birth or pregnancy.</td></tr>
</table></td></tr>
</table>

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				<table><tr><td></td><td>• Infant's age (gestational age, if premature). • Mother's hospital discharge date or infant's hospital discharge date. • Documentation of mother's intent to breastfeed. Documentation must be kept in the beneficiary's file and made available upon request.</td></tr><tr><td>PA Requirements</td><td>PA is not required when the Standards of Coverage are met. PA is required for circumstances beyond the Standards of Coverage and Payment Rules.</td></tr><tr><td>Payment Rules</td><td>All personal use double electric breast pumps are purchase only. Payment includes: • Education for the proper use, care of the equipment, and storage of breast milk. • Supplies necessary for operation of the pump (pump, adapter/charger, breast shields, bottles, lids, tubing, locking ring, connectors, valves, filters and membranes. The pump may be billed using the infant's Medicaid ID number if the need for the pump meets the Standards of Coverage and the mother loses Medicaid eligibility. Medicaid will not purchase a personal use double electric breast pump during the rental period of a hospital-grade electric breast pump or if a manual breast pump was purchased within the Standards of Coverage frequency limitations. Replacement parts are covered after the manufacturer's warranty has expired for included parts. Refer to the Medical Supplier database and the Medicaid Code and Rate Reference tool for covered replacement parts, code descriptions, coverage limitations and reimbursement.</td></tr></table>

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

<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>2.5.C. Manual Breast Pump (new subsection)</td><td>New subsection text reads:

<table>
<tr><td>Definition</td><td>A manual breast pump typically consists of a single breast shield, a collection device and a hand-controlled lever to create suction and express milk. Manual breast pumps are intended for a single user.</td></tr>
<tr><td>Standards of Coverage</td><td>A manual breast pump may be covered once per birth. For a beneficiary who has had a multiple birth delivery, only one pump is covered. Coverage of a manual breast pump may be provided when all of the following criteria have been met:
• The mother expresses the desire to breastfeed.
• The pump has been registered with the FDA.
• The pump has a minimum of a one year manufacturer's warranty.
• The pump has a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma.
• The pump collection bottle must be bisphenol-A (BPA) and DHEP-free.</td></tr>
<tr><td>Documentation</td><td>Documentation must be less than 30 days old and include all of the following:
• An order signed by the treating physician or non-physician practitioner.
• The International Classification of Diseases (ICD) diagnosis code(s) related to birth or pregnancy.
• Infant's age (gestational age, if premature).
• Mother's hospital discharge date or infant's hospital discharge date.
• Documentation of mother's intent to breastfeed.

Documentation must be kept in the beneficiary's file and made available upon request.</td></tr>
<tr><td>PA Requirements</td><td>PA is not required when the Standards of Coverage are met. PA is required for circumstances beyond the Standards of Coverage and Payment Rules.</td></tr>
<tr><td>Payment Rules</td><td>All manual breast pumps are purchase only. Purchase includes:
• Education for the proper use, care of the equipment, and storage of breast milk.
• Supplies necessary for the operation of the pump (pump, breast shields, bottles, lids, tubing, locking ring, connectors, valves, filters and membranes).

The pump may be billed using the infant's Medicaid ID number if the need for the</td></tr>
</table>
</td></tr>
</table>

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				pump meets the Standards of Coverage and the mother loses Medicaid eligibility. Medicaid will not purchase a manual breast pump during the rental period of a hospital-grade electric breast pump or if a personal use double electric breast pump was purchased within the Standards of Coverage frequency limitations. Replacement parts are covered after the manufacturer's warranty has expired for included parts. Refer to the Medical Supplier database and the Medicaid Code and Rate Reference tool for covered replacement parts, code descriptions, coverage limitations and reimbursement.
			2.5.D. Non-Covered Breastfeeding Items (new subsection)	New subsection text reads: Non-covered breastfeeding items: • Personal use single electric breast pumps • Breastfeeding pillows • Breastfeeding comfort items and clothing • Accessories not necessary for the operation of the breast pump
MSA 14-59	12/1/2014	Billing & Reimbursement for Institutional Providers	6.2.J. Inpatient Hospital Claim Requirements for Newborns	Subsection text was revised to read: Providers are required to adhere to NUBC guidelines for reporting newborn priority (type of) admission or visit, newborn birth weight, and cesarean sections/inductions related to gestational age. Birth weight should be reported as a whole number. For example, if the birth weight is 2764.5 grams, then the NUBC value code should be reported as "2765". Claims that fail to report newborn priority (type of) admission or visit and newborn birth weight will be denied.
		Hospital Reimbursement Appendix	Section 5 - Capital	Text was revised to read: Reimbursement for capital costs is made using prospective capital payments. The prospective capital payment amount is calculated using fee-for-service data from the second previous state fiscal year with occupancy limits as described below. Transfer claims will not receive a prospective capital payment. Medicare's Principles of Reimbursement are used to determine Medicaid's share of allowable capital costs. MDCH policy is used to determine capital reimbursement. Capital amounts will be set annually.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Capital amounts may be adjusted due to significant changes in capital costs that are not reflected in the cost report utilized to set the rate. Hospitals may request a capital rate adjustment by submitting a written request to the MDCH Hospital and Clinic Reimbursement Division.
			5.1 Distinct Part Rehabilitation Units	The subsection title was revised to read: Distinct Part Rehabilitation Units and Freestanding Rehabilitation Hospitals Subsection text was revised to read: For distinct part rehabilitation units and freestanding rehabilitation hospitals, a separate inpatient capital rate will be calculated. The sum of the routine and ancillary costs for fee-for-service (FFS) is divided by the FFS rehabilitation Medicaid days to calculate the hospital-specific prospective per diem rate.
			5.2 CIP Monitoring	The subsection title was revised to read: Medical/Surgical Hospitals Subsection text was revised to read: For medical/surgical hospitals, a separate inpatient capital rate will be calculated. The sum of routine and ancillary costs for FFS is divided by the medical/surgical FFS discharges to calculate the hospital-specific prospective per discharge rate.
			5.4 Capital Cost Settlements	Subsection was removed as information is available in the Reconciliation subsection. Following subsections were re-numbered.
			Section 6 - Medicaid Interim Payments	The subsection title was revised to read: Medicaid Interim Payments and Capital Interim Payments The 1st paragraph was revised to read: Medicaid Interim Payments (MIPs) and Capital Interim Payments (CIPs) are available on a voluntary basis to all inpatient hospitals. MIPs and CIPs are paid on a monthly schedule (12 payments per year). Only hospitals that elect to receive MIPs are eligible to receive CIPs.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				The following text was added after the 3rd paragraph: CIP amounts are set using the most recent available cost data and an estimated impact of any applicable limits on capital. CIP amounts are set annually at the beginning of the hospital's fiscal year. CIPs may be adjusted due to significant changes in capital costs that are not reflected in the most recent cost report. Hospitals wishing to request a CIP adjustment must submit a written request to the MDCH Hospital and Clinic Reimbursement Division (HCRD). (Refer to the Directory Appendix for contact information.) Medicare's Principles of Reimbursement are used to determine Medicaid's share of allowable capital costs. MDCH policy is used to determine capital reimbursement.
			6.4 Reconciliation	The 1st sentence was revised to read: An initial MIP reconciliation is done for operating costs only, and an initial CIP reconciliation is done for capital costs only. The following paragraph was added: For capital cost settlements for hospitals with fiscal years ending on and after January 1, 2002, filed cost reports, instead of audited cost reports, are used to complete a hospital desk review and settlement prior to issuing a Notice of Program Reimbursement. Medicaid does not wait for Medicare to complete its audit of a hospital's cost report before Medicaid does its cost settlement. In order to capture the maximum paid claims data, Medicaid final settlements and corresponding final reconciliations are not calculated earlier than 27 months after the end of a hospital's fiscal year end.
			6.6 Monitoring	The following text was added as a 6th paragraph: CIPs are monitored based on quarterly reports submitted by the provider. These reports are due 30 days after the end of the quarter. Adjustments to CIPs are made quarterly where significant changes in utilization are shown.
MSA 14-56	12/1/2014	Billing & Reimbursement for Institutional Providers	11.1 Billing Instructions for Hospice Claim Completion	The following paragraph was added at the end of current text: The Michigan Medicaid program, including Medicaid Health Plans (MHPs) and MIChild, as well as CSHCS, covers hospice care for children under 21 years of age concurrently with curative treatment of the child's terminal illness when the child qualifies for hospice as described in the Hospice Chapter of this manual.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Hospice services and curative treatment are billed and reimbursed separately under this policy. Prior to billing, it is important that providers differentiate between services that are palliative and therefore included in hospice reimbursement, and those that are curative and separately reimbursable under Medicaid. Each child's circumstances will need to be taken into consideration when making this distinction. Caution should be taken to avoid billing both the hospice and Medicaid for the same service as this represents double billing and may constitute fraud.
		Hospice	6.8 Concurrent Hospice and Curative Care for Children	Subsection text was revised to read: Children under 21 years of age may receive hospice care concurrently with curative treatment of the child's terminal illness. This allows the beneficiary or beneficiary's representative to elect the hospice benefit without forgoing any curative service to which the child is entitled under Medicaid for treatment of the terminal condition. The need for hospice care must by certified by a physician and the hospice medical director. Under concurrent curative care policy, curative care is defined as medically necessary care that serves to eliminate the signs and symptoms of a disease with the goal of a cure or long-term disease-free state. Medicaid will reimburse for the curative care separately from the hospice services. Medicaid will not reimburse for these types of treatments when they are used palliatively. Palliative care under hospice is defined as an active patient and family-centered interdisciplinary approach to pain and symptom management of the terminal illness. Palliative care is always a part of hospice and included in the hospice per diem reimbursement. The term "palliative care" cannot be separately billed or reimbursed by Medicaid. A child receiving hospice will continue to receive appropriate early and periodic screening, diagnosis and treatment (EPSDT) services to the extent these services are medically necessary. Pediatric Subspecialist: A pediatric subspecialist must direct the curative care related to the beneficiary's terminal diagnosis. For purposes of this policy, a pediatric subspecialist is a physician who is board certified, or board eligible for subspecialty certification, in a pediatric subspecialty including, but not limited to, neurology, cardiology, pulmonology, endocrinology, or oncology. In most cases, a general pediatrician will not be considered a pediatric subspecialist relative to this policy, but a general pediatrician may assume the role of

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				pediatric subspecialist and direct the child's curative care if they have acted as the primary care provider and treated the child's terminal condition prior to the election of hospice. Note: Beneficiaries with CSHCS-only coverage, meaning no Medicaid coverage and receiving hospice related to the CSHCS qualifying condition, must have a pediatric subspecialist for that condition manage the concurrent curative treatment of the terminal condition.
				Coordination of Care: The hospice provider and pediatric subspecialist must work together to ensure a collaborative approach to the care of the beneficiary. The hospice Plan of Care (POC) must demonstrate coordination of care between the hospice and the pediatric subspecialist. It is the responsibility of each provider working collaboratively to determine whether a service is curative or palliative (hospice). The hospice record must contain a signed statement or attestation from the pediatric subspecialist explaining the course of treatment and acknowledging the physician is aware the beneficiary is receiving hospice services concurrently with curative treatment. The attestation must be dated and present in both the hospice and pediatric subspecialist records within 30 days after the beneficiary is admitted into hospice. The signature, printed name, and National Provider Identifier (NPI) number of the physician ordering and coordinating the concurrent curative treatment must be documented on the attestation. For a beneficiary enrolled in a Medicaid Health Plan (MHP), the hospice provider and pediatric subspecialist must also work with the MHP to ensure that the MHP authorization and documentation requirements are met.
				Billing and Reimbursement: Hospice services and curative treatment are billed and reimbursed separately under this policy. Prior to billing, it is important that providers differentiate between services that are palliative and therefore included in hospice reimbursement, and those that are curative and separately reimbursable under Medicaid. The MDCH recognizes the challenge this poses for providers, and each child's circumstances will need to be taken into consideration when making this distinction. The table below provides examples of treatment and related service categories but is not all-inclusive or intended to represent fixed parameters for decision making. Caution should be taken to avoid billing both the hospice and Medicaid for the same service as this represents double billing and may constitute fraud.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE

Examples of Treatment and Service Categories

Treatment	Hospice Service	Concurrent Curative Service	Both Hospice and Concurrent Curative Services	Comments
Pain/Symptom Management				
Narcotics, Analgesics	X			
Antiemetics	X			
Nutrition				
Tube Feeding			X	Hospice = Continuation of previous tube feedings. Concurrent = Tube placement; initiating feedings.
Intravenous (IV) Fluids		X		Concurrent = Surgical central line placement
Total Parenteral Nutrition (TPN)		X		
Respiratory Support				
Oxygen	X			

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE

Bilevel Positive Airway Pressure (BiPAP)			X	Hospice = < 72 hr Concurrent = Acute event not related to terminal illness
Continuous Positive Airway Pressure (CPAP)			X	
Ventilator		X		
Respiratory Vests			X	
Cough Assist Device(s)			X	
Pharmacy				
Antibiotics	X			Antibiotic administration through available access
Chemotherapy		X		
Intravenous immunoglobulin		X		
Blood Products		X		
Supports				
Spiritual Support	X			
Psychological/Social Support	X			
Bereavement Support	X			

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				<table><tr><td>**Radiation**</td><td></td><td>X</td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td>**Durable Medical Equipment (DME)**</td><td></td><td></td><td></td><td></td></tr><tr><td>Specialized Seating</td><td></td><td>X</td><td></td><td></td></tr><tr><td>Wheelchairs</td><td>X</td><td></td><td></td><td></td></tr></table>
MSA 14-53	12/1/2014	Nursing Facility Coverages	12.1 Hospital Swing Beds	The 4th paragraph was removed. The following text was inserted: A hospital swing bed provider must not provide extended care services if the hospital owns or operates a hospital long-term care unit that has beds available at the time a patient requires admission for extended care services.
MSA 14-50	12/1/2014	Laboratory	2.7 Billing for Services Performed by Reference Laboratories Under Arrangement with Enrolled Hospital Laboratories (new subsection)	New subsection text reads: Following Medicare guidelines and applicable state and federal laws in situations where an enrolled hospital laboratory must refer a specimen to a reference laboratory, the enrolled laboratory will be allowed to bill Medicaid for the services provided by the reference laboratory under the following conditions: • The reference laboratory holds the required Clinical Laboratory Improvement Amendments (CLIA) certification and state licensure, if required, to perform the test; • The enrolled hospital laboratory and the reference laboratory have a contractual agreement (termed "Under Arrangements" by Medicare) to provide such services, with the hospital laboratory responsible for reimbursing the reference laboratory for the services; and • If the service requires prior authorization, the enrolled hospital laboratory must request and receive prior authorization approval for the service to be performed by the reference laboratory. The prior authorization number must be included on the claim. The definitions of reference laboratory and referring laboratory may be found in the Glossary Appendix.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Glossary Appendix		Addition of: **Reference Laboratory** – An enrolled laboratory that receives a specimen from another referring laboratory for testing and that actually performs the test. **Referring Laboratory** – A laboratory that receives a specimen to be tested and that refers the specimen to another laboratory for performance of the laboratory test.
MSA 14-49	12/1/2014	Children's Special Health Care Services	2.4 Children's Multi-Disciplinary Specialty (CMDS) Clinic Enrollment (new subsection)	Refer to the Medicaid Provider Manual for complete language. Includes the following subsections: • 2.4.A. Explanation of Services • 2.4.B. CMDS Clinic Staff Requirements • 2.4.C. CMDS Clinic Visit Types • 2.4.C.1. Initial Comprehensive Evaluation • 2.4.C.2. Basic and Ongoing Comprehensive Evaluation • 2.4.C.3. Management/Follow-Up Visits • 2.4.C.4. Support Service Visits • 2.4.D. Additional Responsibilities • 2.4.E. CMDS Clinic Fee Billing Instructions
			9.8 Children's Multi-Disciplinary Specialty (CMDS) Clinics (new subsection)	New subsection text reads: Children's Multi-Disciplinary Specialty (CMDS) Clinics provide a coordinated, interdisciplinary approach to the management of specified complex medical diagnoses. Services are provided by a team of pediatric specialty physicians and other appropriate health care professionals. When a beneficiary has more than one condition that could be served by more than one CMDS Clinic, it is required that only one CMDS Clinic assumes the care and coordination responsibility for the beneficiary. This will ordinarily be the responsibility of the CMDS Clinic that serves the most complex diagnosis. The CMDS Clinic fees may only be reimbursed to one of the CMDS Clinics if the beneficiary is utilizing the services of more than one CMDS Clinic.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				CMDS Clinic services are reserved for those beneficiaries who have CSHCS and have at least one of the conditions for which CMDS Clinics are available. Additional clinic information is available on the MDCH website. (Refer to the Directory Appendix for website information.)
MSA 14-48	12/1/2014	Federally Qualified Health Centers	Section 1 – General Information	The last paragraph was revised to read: States may elect to reimburse FQHCs under the PPS methodology outlined in the Act or they may choose to implement an alternative payment methodology, referred to as the Memorandum of Agreement (MOA). The MOA must be agreed to by both the state and the FQHC. If an alternative payment methodology is implemented, it must result in payment at least equal to that which an FQHC would receive under the PPS. Refer to the Alternative Payment Methodology subsection of this chapter for additional information.
			1.1 Memorandum of Agreement for Reimbursement	Subsection was removed. Information is available in the Alternative Payment Methodology subsection.
			1.3 Site Specific Certification	Text was revised to read: FQHCs are required to report CMS and Health Resources and Services Administration (HRSA) site-specific certification numbers for each site operated by the FQHC as part of the CHAMPS PE online enrollment process. Satellite(s) and/or mobile center(s) locations not approved by HRSA as a Section 330 eligible site will not be eligible for PPS or MOA reimbursement. FQHCs are required to notify the MDCH Hospital and Clinic Reimbursement Division (HCRD) in writing within seven (7) business days of any of the following changes: • HRSA notification of lost FQHC status; or • Opening(s) and/or closing(s) of any HRSA approved satellite(s) and/or mobile center(s) sites.
			1.4 Allowable Places of Service	Subsection text was revised to read: Services provided to beneficiaries within the four walls of the FQHC and approved FQHC satellite(s) and/or mobile center(s) are allowable for reimbursement under the PPS or the MOA. Off-site services provided by employed practitioners of the FQHC to beneficiaries temporarily homebound or in any assisted living or skilled nursing facility because of a medical condition that prevents the beneficiary from

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				traveling to the FQHC are also allowable for reimbursement under the PPS or the MOA. If a practitioner employed by an FQHC provides services at an inpatient hospital, the service must be billed under the individual practitioner's NPI and will be reimbursed the appropriate fee screen rate. Services performed in an inpatient hospital setting are not included under the PPS or MOA. The costs that are associated with these services must be excluded from the FQHC's Medicaid Reconciliation Report.
			2.1 Primary Care Services	The 3rd bullet point was removed.
			Section 4 - Billing	The following text was added as the 1st sentence. FQHC providers are expected to practice in accordance with the accepted standards of care and professional guidelines applicable to medical, dental, and behavioral health services, and comply with all applicable policies published in the Michigan Medicaid Provider Manual. The following text was added at the end of the last paragraph: Inappropriate payments identified in post-payment review are subject to recoupment. The FQHC has the full responsibility to maintain proper and complete documentation to verify the services provided.
			5.5 Prospective Payment Rate	The following text was added at the end of the paragraph: The per visit amount is adjusted annually using the Medicare Economic Index (MEI) based on changes in the MEI for the prior calendar year.
			5.6 Prospective Payment Rate for New FQHC Sites	In the 2nd paragraph, the 1st sentence was revised to read: Newly established FQHCs shall be paid using the PPS methodology or may agree to payment in accordance with the MOA.

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			5.9 Alternative Payment Methodology	Subsection text was revised to read: In accordance with State Plan authority, MDCH may enter into an alternative payment methodology with an FQHC, referred to as a Memorandum of Agreement (MOA). Reimbursement for Medicaid primary care services provided by an FQHC to Medicaid beneficiaries is subject to the terms of the signed MOA. For an FQHC paid under the MOA, the PPS base methodology described within this chapter will be maintained to ensure compliance with Section 1902(bb)(6)(B) of the Social Security Act. The MOA is effective when both MDCH and an FQHC are signatories to the document. CMS, rather than the State, is the final arbiter of the permissibility of this agreement. The signed agreement does not supersede any corresponding policy in the Michigan Medicaid Provider Manual, but documents the clinic's acceptance of the terms outlined in the Michigan Medicaid State Plan. If an FQHC does not sign the MOA, reimbursement and corresponding policy defaults to that which is described under the PPS methodology and outlined in this manual.
			5.11.A. Reasonable Costs	Text was revised to read: Reasonable costs are defined as the per visit amount approved and paid by Medicare as of October 1, 2001, and then adjusted to reflect the cost of providing services to Medicaid beneficiaries who are not covered by Medicare.
		Acronym Appendix		Addition of: HRSA - Health Resources and Services Administration
MSA 14-47	10/30/2014	Dental	1.1. A. Early and Periodic Screening, Diagnosis and Treatment	Text was revised to read: The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is available to all Medicaid beneficiaries under the age of 21. This program was established to detect and correct or ameliorate defects and physical and mental illnesses and conditions discovered in children. Under EPSDT, dental services are to be provided at intervals which meet reasonable standards of dental practice. Primary Care Physicians (PCPs) should provide an oral health screening and caries risk assessment for beneficiaries under 21 years of age at each well child visit. As an oral health intervention, providers should apply fluoride varnish to high-risk children from birth to 35 months of age up to four times in a 12-month time period.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Providers must complete the online Children's Oral Health training modules and obtain certification prior to providing oral health screenings and fluoride varnish applications. Providers who complete the certification requirements are allowed to bill Medicaid for these services. Specific certification requirements are available on the MDCH Oral Health website. (Refer to the Directory Appendix for website information). Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.
			1.1. B. Early and Periodic Screening, Diagnosis and Treatment Dental Periodicity Schedule	Subsection text was revised to read: The Dental Periodicity Schedule follows the American Academy of Pediatric Dentistry (AAPD) Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling schedule. (Refer to the Directory Appendix for AAPD website information.) The AAPD guidelines are designed for the care of children developing normally and without contributing medical conditions. The guidelines include recommendations to modify as needed for children with special health care needs, disease or trauma. The AAPD guidelines emphasize the importance of early professional intervention and continuity of care based on the individualized needs of the child. The guidelines recommend that a child have a first dental visit when the first tooth erupts or no later than 12 months of age. The examination is to be repeated every six months or as indicated by the child's risk status and susceptibility to disease. The examination includes assessment of pathology and injuries, growth and development, and caries-risk assessment. Based on clinical findings and susceptibility to disease, the timing and frequency of radiographic imaging, oral prophylaxis, and topical fluoride should be provided as determined necessary. Systemic fluoride supplementation should be considered when fluoride exposure is suboptimal. Anticipatory guidance/counseling should be an integral part of each dental visit. Counseling on oral hygiene, nutrition/dietary practices, injury prevention, and nonnutritive oral habits should be included. A referral for speech/language development should be made as needed. Determined by growth and developmental assessment, the prevention and treatment of developing malocclusion should be evaluated beginning at 2 years of age. Following current policy, caries-susceptible pits and fissures of teeth should have sealants placed as soon as possible after eruption. Children 6 years of age and older should receive counseling on substance abuse and intraoral and perioral piercing. Children 12 years of age and older need third molar assessment and potential removal as deemed medically necessary.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Early and Periodic Screening, Diagnosis and Treatment	9.1 Oral Health Screen and Fluoride Varnish	Subsection text was revised to read: Providers should complete an oral health screening and caries risk assessment for beneficiaries under 21 years of age at intervals indicated by the Dental Periodicity Schedule. (Refer to the Directory Appendix for website information on the American Academy of Pediatric Dentistry (AAPD) Caries Risk Assessment Tool.) Children who have been determined to be at risk of development of dental caries or who fall into recognized risk groups should be directed to establish a dental home when the first tooth erupts or no later than 12 months of age. As an oral health intervention, providers should apply fluoride varnish to high-risk children from birth to 35 months of age up to four times in a 12-month time period. Providers must complete the online Children's Oral Health training modules and obtain certification prior to providing oral health screenings and fluoride varnish applications. Providers who complete the certification requirements are allowed to bill Medicaid for these services. Specific certification requirements are available on the MDCH Oral Health website. (Refer to the Directory Appendix for website information.)
			9.2 Periodicity Schedule for Dental Providers	Subsection text was revised to read: The Dental Periodicity Schedule follows the AAPD Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling schedule. The guidelines recommend that a child have a first dental visit when the first tooth erupts or no later than 12 months of age. The examination is to be repeated every six months or as indicated by the child's risk status and susceptibility to disease.
		Directory Appendix	Provider Resources – American Academy of Pediatric Dentistry (AAPD)	Addition of: **Web Address:** http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf **Information Available/Purpose:** Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling **Web Address:** http://www.aapd.org/media/Policies_Guidelines/G_CariesRiskAssessment.pdf) **Information Available/Purpose:** Caries Risk Assessment Tool

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 14-36	12/1/2014	General Information for Providers	Section 9 – Inpatient Hospital Authorization Requirements	The 2nd paragraph was revised to read: All inpatient admissions must be medically necessary and appropriate, and all services must relate to a specific diagnosed condition. In the event that an inpatient stay is deemed medically inappropriate or unnecessary, either through a pre-payment predictive modeling review or a post-payment audit, providers are allowed to submit an outpatient claim for all outpatient services and any inpatient ancillary services performed during the inpatient stay. Elective admissions, … The 3rd paragraph was revised to read: Medically inappropriate or unnecessary inpatient admissions may be resubmitted as outpatient claims for all outpatient services and any inpatient ancillary services performed during the inpatient stay. When an inpatient claim is deemed medically inappropriate or unnecessary through a pre-payment predictive modeling review or a post-payment audit, hospitals are allowed to submit a hospital outpatient Type of Bill (TOB) 013X for all outpatient services and any inpatient ancillary services performed during the inpatient stay. Examples of services related to medically inappropriate or unnecessary inpatient admission include: …
MSA 14-19	5/29/2014	Hospital Reimbursement Appendix	7.3.D. Outpatient Uncompensated Care DSH Pool	In the 1st paragraph, text after the 1st sentence was revised to read: The Outpatient Uncompensated Care DSH Pool will be split into Small and Rural and Large-Urban components. A historical record of the pool amounts can be found on the MDCH website. (Refer to the Directory Appendix for website information.) Payments from the pool … The 3rd paragraph (including table) was removed.
MSA 14-17	5/1/2014	Hospital Reimbursement Appendix	7.7 Special Outpatient Hospital Adjuster Pools	Subsection was removed. The funding methodology for this pool was converted from Medicaid to Children's Health Insurance Program (CHIP), and is no longer applicable to the Hospital Reimbursement Appendix.
			7.7.A. Children's Hospital Pool	Subsection was removed. The funding methodology for this pool was converted from Medicaid to Children's Health Insurance Program (CHIP), and is no longer applicable to the Hospital Reimbursement Appendix. The following subsections were re-numbered.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 13-13	5/1/13	Federally Qualified Health Centers	3.4 Substance Abuse Coordinating Agency	Text was revised to read: Selected services provided by an FQHC will be included in the FQHC annual reconciliation when a contract exists between the FQHC and the behavioral health contracting entity. FQHCs that have a contract in place with a behavioral health agency must follow the service and billing arrangements set forth by the contract. Refer to the Medical Clinics and/or Federally Qualified Health Centers databases on the MDCH website or the Medicaid Code and Rate Reference tool for additional information. (Refer to the Directory Appendix for website information.)

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