MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 09-49

Distribution: All Providers

Issued: September 1, 2009

Subject: Updates to the Medicaid Provider Manual; Healthcare Common Procedure Coding System (HCPCS) Code Changes

Effective: October 1, 2009

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 October 2009 update of the online version of the Medicaid Provider Manual. Attachments to this bulletin describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change. Attachment II describes changes made to incorporate information from recently issued Medicaid Bulletins. These changes appear in green in the online version of the manual.

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

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

HCPCS Code Changes

Providers are being notified of three HCPCS code changes that will be implemented by MDCH. Please note that this notice is distributed to a broad range of providers and not all or any of the codes listed may apply to your scope of practice. The coding information provided is based on the most recent file from the Centers for Medicare & Medicaid Services (CMS).

Code	Code Description	Comment
Q2024	Injection, Bevacizumab, 0.25 mg.	new coverage effective for dates of service on and after 10/1/09; for physicians and outpatient hospitals
S0189	Testosterone Pellet, 75 mg.	new coverage effective for dates of service on and after 10/1/09; for physicians only (does not include outpatient hospitals)
S0162	Injection, Efalizumab, 125 mg.	discontinued coverage effective 7/1/09; for physicians and outpatient hospitals

Information regarding fee screens and coverage parameters is located in the appropriate databases available on the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Public Comment

The Technical Changes Attachment of this bulletin is being issued for public comment of the policy promulgation process concurrently with the implementation of the changes noted in this bulletin. Any interested party wishing to comment on the changes may do so by submitting comments in writing to:

Michigan Department of Community Health
Medical Services Administration
P.O. Box 30479
Lansing, Michigan 48909-7979
Or
E-mail: MSADraftPolicy@michigan.gov

If responding by e-mail, please include "Technical Changes Comment" in the subject line. Comments should be submitted no later than September 30, 2009.

Comments received will be considered for revisions to the changes implemented by this bulletin.

Manual Maintenance

If using the CD version of the Medicaid Provider Manual, retain this bulletin and those referenced in this bulletin. If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy and Forms, this bulletin and those referenced in this bulletin may be discarded.

Questions

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

Approved

Stephen Fitton, Acting Director
Medical Services Administration

Medicaid Provider Manual October 2009 Updates

TECHNICAL CHANGES*

<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td>Ambulance</td><td>2.3.A. ALS 1 Non-Emergency</td><td>The paragraph is revised to read:
When medically necessary, the ALS 1 base rate may be billed when an advanced life support provider (minimum level of EMT-Intermediate or Paramedic) renders an assessment or furnishes one or more ALS interventions.</td><td>Correction. Providers may bill ALS if they perform the specified services. It does not matter whether ALS is specified as the minimum level of service or not.</td></tr>
<tr><td>Billing & Reimbursement for Institutional Providers</td><td>5.3 Pre-Admission and Certification Evaluation Review</td><td>In the 4th paragraph, table – "Readmissions (DRG Hospitals Only)", the last sentence is revised to read:
"... monies are recovered from the hospital."</td><td>To clarify practitioner policy, reference to "admitting physician" was removed.</td></tr>
<tr><td>Billing & Reimbursement for Institutional Providers</td><td>8.3 Blood Lead Poisoning Nursing Assessment/ Investigation Visits</td><td>In the 2nd paragraph, the third bullet was deleted.</td><td>No longer applicable; appropriateness/necessity will be assessed via post-payment review.</td></tr>
<tr><td>Billing & Reimbursement for Institutional Providers</td><td>Section 9 - Private Duty Nursing Agency Claim Submission/Completion</td><td>The following text was added:
Providers must bill MDCH directly (either paper or electronically). When direct billing to MDCH, note the following:
<table>
<tr><td>Service Dates</td><td>Each date of service must be reported on a separate claim line.</td></tr>
<tr><td>Hours/Units</td><td>Each service line must contain the number of units of care in the "Serv. Units" for that date of service.</td></tr>
<tr><td>Prior Authorization</td><td>The PA number listed on the Medicaid authorization letter must be recorded on the claim.</td></tr>
<tr><td>Authorization Letter</td><td>The provider must retain the authorization letter for private duty nursing in the beneficiary's record. The authorization letter should not accompany the claim when billing.</td></tr>
</table></td><td>Clarification and uniformity between billing and reimbursement chapters.</td></tr>
</table>

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

TECHNICAL CHANGES*

<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td></td><td></td><td><table>
<tr><td>Plan of Care</td><td>A plan of care should not be submitted to Medicaid unless specifically requested by MDCH.</td></tr>
<tr><td>Billlable Units</td><td>The total number of units reported must not exceed the total units that were authorized for that month. (PDN services are authorized in hour increments. One hour equals four 15-minute units.) Refer to the Payment in 15-Minute Increments section for additional information.</td></tr>
<tr><td>Adjustments</td><td>Adjustments to claims are made through a total claim replacement or void/cancel process.</td></tr>
</table></td><td></td></tr>
<tr><td>Billing & Reimbursement for Institutional Providers</td><td>9.2.A. Revenue Codes/HCPCS Codes/Modifiers</td><td>The last line in the table was revised to read:

For ratios of more than 2 patients per nurse, the provider must contact the entity authorizing the beneficiary's PDN services: Medicaid Program Review Division, Home and Community Based Services Waiver for the Elderly and Disabled, Children's Waiver (the Community Mental Health Services Program), or Habilitation Supports Waiver (the Community Mental Health Services Program). These ratios are considered exceptional cases and require prior approval.</td><td>Update</td></tr>
<tr><td>Billing & Reimbursement for Institutional Providers</td><td>9.2.C. Multiple Beneficiaries Seen at Same Location</td><td>The 2nd sentence was revised to read:

The specific procedure codes listed in the HCPCS Codes/Modifiers section must be used …</td><td>Clarification</td></tr>
<tr><td>Billing & Reimbursement for Professionals</td><td>Section 3 – Claim Completion</td><td>In the table, for Item #23, the following was added as a 3rd paragraph under "Explanation":

NOTE: DO NOT report the PACER number here which authorizes the inpatient admission.</td><td>Clarification</td></tr>
</table>

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<tr><td>Billing & Reimbursement for Professionals</td><td>6.13 Maternity Care Services</td><td>Under "Coding", the second sentence was revised to read:

Bill the global obstetrical package or the antepartum, delivery, and postpartum components as appropriate per CCI guidelines.

Under "Global Service", the following was added as a 2nd sentence:

The provider or group may choose to bill the antepartum, delivery, and postpartum components separately as allowed by CCI editing.</td><td>To reflect optional component billing as allowed by CCI editing.</td></tr>
<tr><td>Billing & Reimbursement for Professionals</td><td>6.15.A. Direct Billing to MDCH (re-numbered)</td><td>Subsection was previously numbered 6.15.B.

Text was revised to read as follows:

Providers must bill MDCH directly (either paper or electronically). When direct billing to MDCH, note the following:
<table>
<tr><td>Place of Service</td><td>The Place of Service code on the claim must indicate "Home".</td></tr>
<tr><td>Service Dates</td><td>Each date of service must be reported on a separate claim line.</td></tr>
<tr><td>Hours/Units</td><td>Each service line must contain the number of units of care in the "Days" or "Units" item for that date of service.</td></tr>
<tr><td>Prior Authorization</td><td>The PA number listed on the Medicaid authorization letter must be recorded on the claim.</td></tr>
<tr><td>Authorization Letter</td><td>The provider must retain the authorization letter for private duty nursing in the beneficiary's record. The authorization letter should not accompany the claim when billing.</td></tr>
<tr><td>Plan of Care</td><td>A plan of care should not be submitted to Medicaid unless specifically requested by MDCH.</td></tr>
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<tr><td>Billable Units</td><td>The total number of units reported must not exceed the total units that were authorized for that month. (PDN services are authorized in hour increments. One hour equals four 15-minute units.) Refer to the Payment in 15-Minute Increments section for additional information.</td></tr>
<tr><td>Adjustments</td><td>Adjustments to claims are made through a total claim replacement or void/cancel process.</td></tr>
<tr><td>Multiple Beneficiaries Seen At Same Location</td><td>The appropriate procedure codes must be used if an RN or LPN is caring for more than one beneficiary at the same location for which this approach to staffing has been authorized. These procedure codes must be used for each beneficiary provided care (i.e., first, second beneficiary).

For example, if there is one RN caring for two children at the same location, the multiple beneficiary code must be used for both children. Procedure codes to be used for billing private duty nursing are available on the MDCH website in the Private Duty Nursing Reimbursement Rates Database.</td></tr>
<tr><td>Holidays</td><td>Additional reimbursement for holidays on which private duty nursing services are provided is allowed. Current recognized holidays are: New Year's Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving Day, and Christmas Day.</td></tr>
</table>
</td><td></td></tr>
<tr><td>Billing & Reimbursement for Professionals</td><td>6.15.B. HCPCS Codes/Modifiers (new subsection)</td><td>The following new subsection text was added:

When billing, the provider must use the following codes. The HCPCS Codes/Modifiers are located in the Healthcare Common Procedure Coding System manual.
<table>
<tr><th>Description</th><th>HCPCS Code/Modifier</th></tr>
<tr><td>Nursing Care, RN, Per Hour</td><td>S9123</td></tr>
<tr><td>Nursing Care, RN, Per Hour, Holiday</td><td>S9123</td></tr>
</table>
</td><td>Clarification and uniformity between billing & reimbursement chapters.</td></tr>
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<tr><th>Description</th><th>HCPCS Code/Modifier</th></tr>
<tr><td>Nursing Care, LPN, Per Hour</td><td>S9124</td></tr>
<tr><td>Nursing Care, LPN, Per Hour, Holiday</td><td>S9124</td></tr>
<tr><td>Nursing Care, 1 RN to 2 Patients, Per Hour</td><td>S9123 TT</td></tr>
<tr><td>Nursing Care, 1 RN to 2 Patients, Per Hour, Holiday</td><td>S9123 TT</td></tr>
<tr><td>Nursing Care, 1 LPN to 2 Patients, Per Hour</td><td>S9124 TT</td></tr>
<tr><td>Nursing Care, 1 LPN to 2 Patients, Per Hour, Holiday</td><td>S9124 TT</td></tr>
<tr><td>For ratios of more than 2 patients per nurse, the provider must contact the entity authorizing the beneficiary's PDN services: Medicaid Program Review Division, Home and Community Based Services Waiver for the Elderly and Disabled, Children's Waiver (the Community Mental Health Services Program), or Habilitation Supports Waiver (the Community Mental Health Services Program). These ratios are considered exceptional cases and require prior approval.</td><td></td></tr>
</table>
</td><td></td></tr>
<tr><td>Home Health</td><td>6.1.B. Blood Lead Poisoning Nursing Assessments/Investigation Visits</td><td>The 2nd sentence of the 1st paragraph was deleted.

The 3rd sentence of the 1st paragraph was revised to read:

Medicaid reimburses up to two nurse visits per child, regardless…</td><td>No longer applicable.

Clarification. Appropriateness/necessity will be assessed via post-payment review.</td></tr>
</table>

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Home Health	6.1.F. Neonatal Jaundice	The paragraph was revised to read: Nurse visits related to neonatal jaundice require supporting documentation in the beneficiary's medical record that the nurse visits are required for a specific medical condition. Supporting documentation should include pertinent laboratory values.	Clarification
Hospital	5.2 Pre-Admission and Certification Evaluation Review DRG Inpatient Admissions	The 1st sentence of the 3rd paragraph was revised to read: ... MDCH does not reimburse the hospital for inpatient services rendered. ...	To clarify practitioner policy, reference to "attending physician" was removed.
Hospital	6.7 Private Duty Nursing	In the 2nd paragraph, the bullet list was revised to read: • Children's Waiver (the Community Mental Health Services Program) • Habilitation/Support Services Waiver (the Community Mental Health Services Program) • Home and Community-Based Services Waiver for the Elderly and Disabled (the MI Choice Waiver) The 3rd paragraph was revised to read: For a Medicaid beneficiary who is not receiving services from one of the above programs, the Program Review Division reviews the request for authorization and authorizes the services if the medical criteria and general eligibility requirements are met. In the 4th paragraph, the 1st sentence was revised to read: ... when requesting PDN services for persons with Medicaid coverage. In the 4th paragraph, the following was added as a last sentence: Private Duty Nursing is not a benefit under CSHCS. Individuals with CSHCS coverage may be eligible for PDN under Medicaid.	Clarification and uniformity with Private Duty Nursing chapter.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	6.9.A. Medicaid Ventilator Dependent Care	The following is replacement text appearing after the 7th paragraph: To begin the prior authorization process once a VDCU has agreed to accept the beneficiary, the hospital discharge planner must provide the following documentation to the VDCU: • History and physical from the current hospital admission; • All consults from the current hospital admission; • Any labs, diagnostic testing or procedures pertaining to or impacting the beneficiary's respiratory status; and • Two to three days of current ventilator flow sheets. For status of the authorization, the hospital discharge planners should contact the VDCU. The VDCU will initiate the actual prior authorization with Medicaid.	This section was revised to correspond to a Medicaid Program Review Division letter issued June 29, 2006 stating that Medicaid will only accept prior authorization requests from the vent dependent care unit and not a hospital.
Mental Health/Substance Abuse	1.7 Definition of Terms	In the table, under "Substance Abuse Treatment Specialist", the 3rd bullet was revised to read: • An individual who has one of the following approved alternative certifications: ➢ For medical doctors: American Society of Addiction Medicine (ASAM) ➢ For prevention: Certified Health Education Specialist (CHES) through the National Commission for Health Education Credentialing ➢ For psychologists: American Psychological Association (APA) specialty in addiction and certification through the Upper Midwest Indian Council on Addiction Disorders (UMICAD)	Update
Mental Health/Substance Abuse	2.1 Mental Health and Developmental Disabilities Services	The last bullet was revised to read: … monitored by a behavior treatment committee.	Change in terminology from "behavior management" to "behavior treatment".

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/Substance Abuse	3.3 Behavior Treatment Review (re-named)	The subsection name was changed from "Behavioral Management Review" to "Behavior Treatment Review". Throughout the 2nd paragraph, references to "behavior management" were changed to "behavior treatment".	Change in terminology from "behavior management" to "behavior treatment".
Mental Health/Substance Abuse – Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix	2.4 Child Therapeutic Foster Care	In the 1st paragraph, the last bullet was revised to read: • family behavior treatment skills.	Change in terminology from "behavior management" to "behavior treatment".
Nursing Facility Coverages	11.2.B Authorization for VDCU Placement	The following replaces the 1st paragraph and adds additional language: To begin the prior authorization process once a VDCU has agreed to accept the beneficiary, the hospital discharge planner must provide the following documentation to the VDCU: • History and physical from the current hospital admission; • All consults from the current hospital admission; • Any labs, diagnostic testing or procedures pertaining to or impacting the beneficiary's respiratory status; and • Two to three days of current ventilator flow sheets. In addition to the above, the hospital discharge planner, case manager, or social worker must complete and submit to the VDCU form MSA-1634 (Medicaid Ventilator Dependent Care Assessment). (Refer to the Forms Appendix for a copy of the form and to the Directory Appendix for forms website information.) Once the VDCU has the above documentation, the VDCU may call and request a verbal authorization for Revenue Code 0110 to admit the beneficiary. If a verbal authorization	This section was revised to correspond to a Medicaid Program Review Division letter issued June 29, 2006, stating that Medicaid will only accept prior authorization requests from the vent dependent care unit and not a hospital.

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CHAPTER	SECTION	CHANGE	COMMENT
		is issued, the VDCU can immediately admit the beneficiary and then submit form MSA-1635 (Medicaid Ventilator Dependent Care Authorization) and the above documentation to the Program Review Division within 30 days of admission. (Refer to the Forms Appendix for a copy of the form and to the Directory Appendix for forms website information.)	
Nursing Facility Cost Reporting & Reimbursement Appendix	12.5 Frequency of MIP Payment	The second sentence was revised to read: … will be paid on the first and third Thursday of each month.	Update
Practitioner	8.4 Obstetrical Package vs. Components	In the 1st paragraph, the following language replaces the second sentence: Postpartum care or antepartum care is covered separately if provided by a different physician or group than the physician providing the delivery services. To be consistent with some commercial payers and Medicare, the physician or group providing the entire global obstetrical package may choose to report either the entire global package or may report the antepartum care, delivery, and postpartum care separately as each of these services is provided. Combinations of these components must be allowable under CCI editing. Components such as the antepartum care or postpartum care cannot be unbundled into individual visits.	To reflect optional component billing as allowed by CCI editing.

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CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	11.2 Pre-Admission and Certification Evaluation Review	The 2nd paragraph was revised to read: ... Medicaid does not cover the hospital services rendered. The following was inserted after the 6th paragraph: NOTE: DO NOT report the PACER number on the professional claim. PA numbers and CLIA numbers are required as appropriate on the professional claim. In the 8th paragraph, the 2nd sentence was revised to read: ... the PACER number request for the readmission must be made ...	Clarification
Private Duty Nursing	Section 1 – General Information	In the 3rd paragraph, the bullet list was revised to read: • Children's Waiver (the Community Mental Health Services Program) • Habilitation Supports Waiver (the Community Mental Health Services Program) • Home and Community-Based Services Waiver for the Elderly and Disabled (the MI Choice Waiver) In the 5th paragraph, program names were placed in alphabetical order. In the 6th paragraph, waiver names were placed in alphabetical order.	Clarification and formatting
Private Duty Nursing	1.3 Prior Authorization	In the 1st paragraph, waiver names were placed in alphabetical order.	Formatting

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CHAPTER	SECTION	CHANGE	COMMENT
Private Duty Nursing	1.11 Caring for More Than One Patient at a Time	The 1st sentence was revised to read: For ratios of more than two patients per nurse, the provider must contact the entity authorizing the beneficiary's PDN services: Children's Waiver (the Community Mental Health Services Program), Habilitation Supports Waiver (the Community Mental Health Services Program), Home and Community Based Services Waiver for the Elderly and Disabled (MI Choice Waiver), or the Medicaid Program Review Division.	Update
School Based Services Random Moment Time Study	3.3 Time Study Staff Pools (re-named per bulletin MSA 09-34)	The following was added as the last paragraph: When providing the staff pool list of those eligible to participate in the time studies, school districts must certify the list of participants and activities to be claimed to ensure that all appropriate personnel are submitted and that appropriate credentials are in place for billing Medicaid.	Re-located from subsection 3.3.D. for more appropriate placement of information
School Based Services Random Moment Time Study	3.3.D. Targeted Case Management Services Staff Pool	The last paragraph was deleted.	Re-located to subsection 3.3 for more appropriate placement of information

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 09-45	8/1/09	Nursing Facility Coverages	9.26.D. Beneficiary Pharmacy Insurance Deductible, Co-Insurance, Co-Pays and Premiums (new subsection)	Subsections and language were added as follows: **9.26.D.1. Beneficiary Liability Under Medicare Part D** Beneficiaries who are enrolled in Medicaid and Medicare are considered dual eligibles. Dual eligibles who reside in nursing facilities do not have to pay premiums, co-insurance, deductibles and co-pays for prescription drugs if they are enrolled in a Medicare Part D plan. However, the Medicare Part D benefit requires that Medicaid make a payment(s) for nursing facility care for one full calendar month before the dual eligible is exempt from prescription drug co-pays. Under either Medicare or Medicaid, a nursing facility is not responsible for paying the pharmacy for a beneficiary's liability (co-pays, deductibles, and/or co-insurance) unless the facility has assumed this obligation by contract or such payment is required by state law. **9.26.D.2. Coordination with Medicare Part D** Medicaid does not coordinate benefits with the Medicare Part D benefit. Medicaid does not reimburse a pharmacy for the beneficiary's liability for prescription drugs if the beneficiary is: • Enrolled in a Medicare Part D plan and the prescription drugs are covered under the Medicare Part D benefit. • Eligible to join a Medicare Part D plan but chooses to retain his commercial insurance in place of joining a Medicare Part D plan. If a beneficiary joins a Medicare Part D plan that has a premium more than the Medicare standard premium established for Michigan, the beneficiary must pay the difference in the cost that Medicare does not pay. **9.26.D.3. Conditions When Nursing Facilities Can Offset the Patient-Pay Amount** The following table gives conditions on when a nursing facility can offset the patient-pay amount for the beneficiary's liability for prescription drugs.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE

If	Then
Beneficiary recently enters a nursing facility and his liability is not exempt under the Medicare Part D benefit until Medicaid has made a payment for one month, and it is established that the beneficiary will reside in the nursing facility for one month or more.	Nursing facility can offset the patient-pay amount for the beneficiary's liability during the initial month of the nursing facility stay.
Beneficiary is retroactively enrolled in Medicaid and his liability exemption under the Medicare Part D benefit has not yet taken effect.	The offsetting of the patient-pay amount for the beneficiary's liability can only occur for the first month if the retroactive enrollment in Medicaid is more than one month. The beneficiary's liability for subsequent months must be billed to the Medicare Part D plan by the pharmacy.
Beneficiary is prescribed drugs not covered by Medicare Part D, Medicaid or commercial insurance.	Nursing facility can offset the patient-pay amount.
Beneficiary has pharmacy co-pays, co-insurance, and deductibles from his commercial/private insurance.	Nursing facility can offset the patient-pay amount.

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Nursing facilities cannot offset the patient-pay amount for insurance premiums. Instructions for offsetting the patient-pay amount are contained in the Offset to Patient-Pay Amount for Noncovered Services section in the Billing & Reimbursement for Institutional Providers Chapter. **9.26.D.4. Retroactive Medicaid and Medicare Part D Enrollment** If a beneficiary becomes retroactively enrolled in Medicaid and a Medicare Part D plan, a pharmacy can bill the Medicare Part D plan for the beneficiary's liability during the retroactive period in which the drugs were dispensed. However, in order for the pharmacy to bill Medicare Part D retroactively, the pharmacy must receive proof that Medicare Part D was made retroactive. The nursing facility can assist in getting the appropriate information to the pharmacy by obtaining the proof of retroactive eligibility from the beneficiary or the beneficiary's representative (this could be the facility). The pharmacy cannot make the decision of retroactive eligibility on its own. Hence, it is important that the nursing facility communicate with the pharmacy about the retroactive information so that the pharmacy can bill the Medicare Part D plan. **9.26.D.5. Beneficiaries Ineligible for Medicare Part D** For beneficiaries who are not eligible for the Medicare Part D benefit, Medicaid will continue to coordinate benefits with their commercial/private insurance. **9.26.D.6. Questions on Medicare Part D** Questions regarding a beneficiary's eligibility for Medicare Part D, specific Medicare Part D drug coverage, or retroactive enrollment in Medicare Part D must be directed to Medicare. Also, the Michigan Medicare/Medicaid Assistance Program (MMAP) provides free education and personalized assistance to people with Medicare and Medicaid, their families, and caregivers (including the nursing facility). (Refer to the Directory Appendix for contact information.) Beneficiaries must contact their/their spouse's employer human resources department for questions concerning the coordination of their commercial/private insurance and Medicare Part D.

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BULLETINS INCORPORATED*

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		Directory Appendix	Nursing Facility Resources	Addition of the following: Medicare Part D 1-800-633-4227; TTY: 1-877-486-2048 www.medicare.gov Questions regarding a beneficiary's eligibility for Medicare Part D, specific Medicare Part D drug coverage, or retroactive enrollment in Medicare Part D. Michigan Medicare/Medicaid Assistance Program (MMAP) 1-800-803-7174 Provides free education and personalized assistance to people with Medicare and Medicaid, their families, and caregivers (including the nursing facility).
			Other Health Care Resources/Programs	The Medicare Part D section was revised to read: Medicare Part D 1-800-633-4227; TTY: 1-877-486-2048 www.medicare.gov Questions regarding a beneficiary's eligibility for Medicare Part D, specific Medicare Part D drug coverage, or retroactive enrollment in Medicare Part D. Michigan Medicare/Medicaid Assistance Program (MMAP) 1-800-803-7174 Provides free education and personalized assistance to people with Medicare and Medicaid, their families, and caregivers (including the nursing facility).
MSA 09-41	8/1/09	Billing & Reimbursement for Institutional Providers	9.1 MI AuthentiCare	Subsection deleted due to obsolete information. Following subsections were re-numbered.

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<tr><td></td><td></td><td>Billing & Reimbursement for Professionals</td><td>6.15.A. MI AuthentiCare</td><td>Subsection deleted due to obsolete information. Following subsection was re-numbered.</td></tr>
<tr><td></td><td></td><td>Billing & Reimbursement for Professionals</td><td>6.15.D. Claim Corrections</td><td>Subsection deleted due to obsolete information.</td></tr>
<tr><td></td><td></td><td>Private Duty Nursing</td><td>1.7 Service Log</td><td>Total text revision for this section follows:

If PDN is prior approved and care is initiated, a detailed log for each date of service must be maintained. The service log must be beneficiary specific, with the beneficiary's name and birth date in the header portion of the document. In cases where the nurse is caring for two or more beneficiaries in the same home, a separate service log for each beneficiary must be maintained. This log must be kept in the beneficiary's record.

The following service log provides an example of the required fields.
<table>
<tr><th colspan="7">(Beneficiary Name and Birth Date)</th></tr>
<tr><th>Name</th><th>Date of Service</th><th>Start Time</th><th>Stop Time</th><th>Units*</th><th>Nurse Signature & Date</th><th>Parent/Caregiver Signature & Date</th></tr>
<tr><td>(name RN/LPN)</td><td>10/06/09</td><td>8:00 a.m.</td><td>12:00 p.m.</td><td>16</td><td></td><td></td></tr>
<tr><td>(name RN/LPN)</td><td>10/06/09</td><td>12:00 p.m.</td><td>4:38 p.m.</td><td>19</td><td></td><td></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)

<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>
<table>
<tr><td>(name RN/LPN)</td><td>10/07/09</td><td>8:00 a.m.</td><td>4:00 p.m.</td><td>32</td><td></td><td></td></tr>
<tr><td>(name RN/LPN)</td><td>10/08/09</td><td>8:00 a.m.</td><td>1:00 p.m.</td><td>20</td><td></td><td></td></tr>
</table>
*Refer to the Payment in 15-Minute Increments section for additional information.

The date of the nurse's signature must be the same as the date of service. The date of the parent/caregiver signature should be within one week of the date of service. A claim must not be submitted before the service log is completed for those dates of service.
</td></tr>
<tr><td></td><td></td><td>Private Duty Nursing</td><td>1.12 Billing for Private Duty Nursing</td><td>The 2nd paragraph was deleted due to obsolete information.</td></tr>
<tr><td></td><td></td><td>Directory Appendix</td><td>Private Duty Nursing Resources</td><td>Information regarding MI AuthentiCare was deleted as information is obsolete.</td></tr>
<tr><td>MSA 09-40</td><td>7/15/09</td><td>Hospital Reimbursement Appendix</td><td>7.4 Calculation of DSH Ceiling</td><td>The following was added as the 1st sentence of the 1st paragraph:

Hospital data utilized to calculate hospital-specific DSH ceilings includes inpatient and outpatient data.

The item identified as "3. Selection of Ceiling Option" and the following paragraph were deleted.</td></tr>
<tr><td>MSA 09-35</td><td>7/1/09</td><td>Children's Special Health Care Services</td><td>8.1 Medical Renewal Period</td><td>The 1st paragraph was deleted.

The following was added as the 1st sentence to the 2nd paragraph:

The CSHCS medical renewal period is established at one year, two years, three years, or five years, depending upon the CSHCS primary diagnosis.</td></tr>
</table>

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 09-34 **NOTE:** Bulletin MSA 09-29 indicated that some of these changes were incorporated into the Medicaid Provider Manual as a result of bulletin MSA 09-21. Bulletin MSA 09-21 was rescinded shortly after the release of MSA 09-29; therefore, bulletin incorporation of MSA 09-21 did not occur.	6/16/09	School Based Services	2.1 Individuals with Disabilities Education Act Assessment and IEP/IFSP Development, Review and Revision	The following procedure codes and descriptions were added: 96101 – Psychological testing (Used by the psychologist when billing for the evaluation [HT] when the psychological testing is performed as part of the assessment/evaluation process.) 96116 – Neurobehavioral status exam (Used by the psychologist when billing for the evaluation [HT] when the neurobehavioral status exam is performed as part of the assessment/evaluation process.) 96118 – Neuropsychological testing (Used by the psychologist when billing for the evaluation [HT] when the neuropsychological testing is performed as part of the assessment/evaluation process.)
			3.3.A. Sanctions	The following is added to the bullet list in the 2nd paragraph: • Failure to comply with the federal mandate to submit procedure-specific claims through the Medicaid Management Information System (MMIS).
			6.2.B. Specialized Transportation Reconciliation and Settlement	Text in this subsection is replaced in its entirety with the following: On an annual basis, the cost per trip is calculated by dividing the total Medicaid allowable costs (including indirect cost) by the total ISD-reported special education (specialized) one-way transportation trips. The cost per trip is multiplied by the quantity of Medicaid "allowable" one-way trips gleaned from the Medicaid Invoice Processing system to arrive at the Medicaid allowable cost. An "allowable" one-way trip is one that is provided to a Medicaid beneficiary and fulfills all of the following requirements: • Documentation of ridership is on file;

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				• The need for the specialized transportation service is identified in the Individualized Education Program (IEP)/Individualized Family Service Program (IFSP); and • A Medicaid-covered service (other than transportation) is provided on the same date of service. The Medicaid-covered service must also be documented in the IEP/IFSP. The cost settlement is accomplished by comparing the interim monthly payment totals to the annual Medicaid allowable specialized transportation cost. The cost settlement amount for the specialized transportation is combined with the cost settlement amounts for the Fee For Service (FFS) Direct Medical, Targeted Case Management, and Personal Care Services; any over/under adjustments are processed as one transaction.
		School Based Services Random Moment Time Study	3.3 Time Study Staff Pools (re-named)	The subsection title was re-named. The following was added as the 1st and 2nd paragraphs: To preserve the integrity of the RMTS process and to allow for timely process flow, school staff are given four weeks to review and return the staff pool lists and financials to the Contractor for those staff eligible to participate in each time study group. The staff pool lists must be returned as a complete file with all updates reflected. No partial staff pool list files will be accepted by the Contractor. If staff pool lists and/or financials for the Personal Care Services, the Targeted Case Management, or the Administrative Outreach Program (AOP) time studies are not returned to the Contractor on or before the published deadline, the LEA staff pool lists and correlating financials will be removed from the time study and claim calculation for the affected quarter. ISD coordinators and LEA financial contact staff will be notified.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			3.1.A. Long-Term Substitutes (new subsection)	New subsection language was added as follows: Long-term substitute staff replacing permanent staff on leave may be added to the staff pool lists. The following criteria apply when long-term substitutes are utilized: • A long-term substitute staff must be employed by the ISD/Local Educational Agency (LEA) for at least 30 calendar days within the quarter. • The ISD/LEA may report the name of the long-term substitute staff any time after the sampling moments are distributed. • The long-term substitute staff must meet all of the program requirements and provider qualifications necessary to participate in the Medicaid school based services program staff pool. • The substitute's name must be listed in parentheses behind the name of the regular staff person on the staff pool list. • If listed on the staff pool list, the substitute staff must complete the time study moment. • Financial worksheets must reflect the name of the regular staff and the substitute in parentheses. The cost reflected should be the sum of the cost of the regular staff on leave and the long-term substitute staff. • All audit liability for the financial data reported and the tracking of the moments is the responsibility of the ISD/LEA reporting entity. • All staff whose costs are included in the cost pool, including long-term substitutes, must be included in the sample universe for the time study.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			3.3.A. AOP Only Staff Pool	The following positions were added to the staff pool list: • School Psychologists (certified by the Michigan Department of Education but without Michigan licensure) • Teachers of Speech and Language Impairments (without their American Speech-Language-Hearing Association Certificate of Clinical Competence) • School Social Workers (certified by the Michigan Department of Education but without Michigan licensure)
			3.3.B. AOP & FFS/Direct Medical Services Staff Pool	The bullet reading "Psychologists" is revised to read: • Psychologists (not School Psychologists)
			Section 4 – Administrative Outreach and Direct Medical Activity Code Summary	Code 17(D) was added to the table in the 3rd paragraph.
			4.1.S. Code 17(D) – Non-Returned Moments (new subsection; following subsection re-numbered)	New subsection text added as follows: U – Fee for Service U – Administrative Outreach This code is used for moments that are not returned by the published deadline. As long as the compliance rate remains above 85%, these moments will not be used as a negative factor in the RMTS calculation.
			Section 7 – Summary of Time Study Steps	The 8th bullet was revised to read: • Produce quarterly reports summarizing the results of the random moment time studies (RMTS) and RMTS compliance reporting. (Both reports are forwarded to the MDCH Program Policy Division for posting on the MDCH website. Refer to the Directory Appendix for website information.)

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			8.4 Financial Reporting Compliance Requirements (new subsection)	New subsection text was added as follows: The financial data reported (salaries, benefits, supplies, purchased services, and other expenditures) must be based on actual detailed expenditures from LEA payroll and financial systems. Payroll and financial system data must be applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated must correlate to the claiming period.
MSA 09-33	6/18/09	Nursing Facility Coverages	10.2 Holding a Bed (Hospital Leave and Therapeutic Leave)	The following language was added to the textbox: NOTE: This readmission policy also applies to Medicaid residents admitted before the effective date of the Denial of Payment for New Admissions (DPNA) who take temporary leave before, on, or after the effective date of the DPNA and are not considered new admissions upon return and, therefore, are not subject to the denial of payment.
		Nursing Facility Coverages	10.2.A. Hospital Leave Days	The following text was added as a note to the 14th paragraph: NOTE: If the claim does show discharged, the facility is reminded of Medicaid's readmission policy. The beneficiary must be readmitted immediately to the first available bed if the beneficiary still requires nursing facility services and is still Medicaid eligible. This readmission policy also applies to Medicaid residents admitted before the effective date of the Denial of Payment for New Admissions (DPNA) who take temporary leave before, on, or after the effective date of the DPNA and are not considered new admissions upon return and, therefore, are not subject to the denial of payment.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 09-28	6/1/09	Children's Special Health Care Services Chiropractor Dental Federally Qualified Health Centers Hearing Aid Dealers Practitioner Rural Health Clinics Vision	Table of Contents	A textbox was added to the Table of Contents page for the identified chapters to explain the effect of Executive Order 2009-22 on services. **NOTE:** The textbox in the Dental Chapter reflects the addition of Procedure Code D9999 – Unspecified, adjunctive procedure, by report. This code was not included in bulletin MSA 09-28.

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Supplemental Bulletin List

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. The updated list is posted on the MDCH website along with the Medicaid Provider Manual.

Providers affected by a bulletin should retain it until it is incorporated into the quarterly update of the online version of the manual unless instructed otherwise.

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
9/1/09	MSA 09-49	Updates to the Medicaid Provider Manual; Healthcare Common Procedure Coding System (HCPCS) Code Changes	All Providers	
9/1/09	MSA 09-47	MI Choice Waiver Waiting List	Medicaid Home and Community Based Services Waiver for the Elderly and Disabled (MI Choice Waiver), Nursing Facilities, County Medical Care Facilities, Hospital Long Term Care Units, Hospital Swing Beds, Ventilator Dependent Care Units, Centers for Independent Living	
8/25/09	MSA 09-48	Discontinuance of Private Duty Nursing (PDN) Billing Through MI AuthentiCare, Implementation of PDN Direct Billing in the Community Health Automated Medicaid Processing System (CHAMPS)	Private Duty Nursing	
8/18/09	MSA 09-46	Community Health Automated Medicaid Processing System (CHAMPS) Implementation Update	All Providers	

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DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
8/1/09	MSA 09-45	Reminder on Beneficiary Pharmacy Insurance Deductible, Co-Insurance, Co-Pays and Premiums	Pharmacies, Nursing Facilities, County Medical Care Facilities, Hospital Long-Term Care Units, Hospital Swing Beds, Ventilator Dependent Units	10/1/09 Information incorporated into the Nursing Facility Coverages Chapter.
8/1/09	MSA 09-43	Special Payments to County Medical Care Facilities	County Medical Care Facilities	
8/1/09	MSA 09-42	Sanctioned Providers Update	All Providers	Information incorporated into the Sanctioned Providers List maintained on the MDCH website.
8/1/09	MSA 09-41	Discontinuance of Private Duty Nursing (PDN) Billing Through MI AuthentiCare, Implementation of PDN Direct Billing, and Changes to Service Log	Private Duty Nursing	10/1/09 Information incorporated into the Billing & Reimbursement for Institutional Providers, the Billing & Reimbursement for Professionals, and the Private Duty Nursing Chapters and the Directory Appendix.
7/24/09	MSA 09-44	Inpatient Hospital Payment Reduction	Hospitals	N/A
7/23/09	MSA 09-39	Rate Restoration for Hospice Services	Hospice	Information added to the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Hospice >> Hospice Reimbursement Rates
7/15/09	MSA 09-40	Selection of Disproportionate Share Hospital (DSH) Ceiling Calculation Option	Hospitals	10/1/09 Information incorporated into the Hospital Chapter – Hospital Reimbursement Appendix.

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7/1/09	MSA 09-36	Extension of Hearing Aid Volume Purchase Contract	Hearing Aid Dealers, Audiologists/Hearing Centers, Outpatient Hospitals, Practitioners, Medicaid Health Plans	N/A
7/1/09	MSA 09-35	Change to Children's Special Health Care Services (CSHCS) Medical Renewal Period	Local Health Departments	10/1/09 Information incorporated into the Children's Special Health Care Services Chapter.
6/26/09	MSA 09-37	Rescinding Executive Order 2009-22 Rate Reduction	Hospitals and Nursing Care Facilities	N/A
6/18/09	MSA 09-33	Re-Admission of Beneficiaries on Hospital Leave Prior to a Denial of Payment for New Admissions (DPNA)	Nursing Facilities, County Medical Care Facilities, Hospital Long-Term Care Units, Hospital Swing Beds and Ventilator Dependent Units	10/1/09 Information incorporated into the Nursing Facility Coverages Chapter.
6/16/09	MSA 09-34	Rescind Bulletin MSA 09-21 and Clarifications to the School Based Services and School Based Services Random Moment Time Study Medicaid Provider Manual Chapters	School Based Services Providers	10/1/09 Information incorporated into the School Based Services and the School Based Services Random Moment Time Study Chapters.
6/1/09	MSA 09-32	Home Help Provider Agency Policy Clarification	Home Help Provider Agencies	N/A
5/09	MSA 09-31	Sanctioned Providers Update	All Providers	Information incorporated into the Sanctioned Providers List maintained on the MDCH website.

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6/1/09	MSA 09-30	Community Health Automated Medicaid Processing System (CHAMPS) Implementation Update	All Providers	
6/1/09	MSA 09-29	Updates to the Medicaid Provider Manual	All Providers	7/1/09 Information incorporated throughout the Manual, as appropriate. MDCH website updated, as appropriate.
6/1/09	MSA 09-28	Eliminating Certain Medicaid Benefits for Medicaid Beneficiaries Age 21 and Older, and Medicaid Provider Fee Reductions	All Providers	7/1/09 Information incorporated into the Children's Special Health Care Services, Chiropractor, Dental, Federally Qualified Health Centers, Hearing Aid Dealers, Practitioner, Rural Health Clinics and Vision Chapters. MDCH website updated, as appropriate.
6/1/09	MSA 09-27	New Healthcare Common Procedure Coding System (HCPCS) Procedure Code Coverage and an Adjustment to the Fee Screen for Essure Hysteroscopic Sterilization Provided in the Office Setting	Practitioners, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, Hospitals, Local Health Departments, Medicaid Health Plans, and Mental Health and Substance Abuse	Information added to databases at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information
6/1/09	MSA 09-26	Medicaid Processing and Payment of Nursing Facility Claims for Co-Insurance Days for Beneficiaries with Medicare Advantage Plan Coverage	Nursing Facilities, County Medical Care Facilities, Hospital Long-Term Care Units, Hospital Swing Beds, and Ventilator Dependent Units	N/A

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5/15/09	MSA 09-24	Executive Order 2009-22 Eliminating Funding for the Single Point of Entry (Long-Term Care Connection) Demonstration Project	Hospice, Hospitals, Medicaid Health Plans, Mental Health/Substance Abuse (Prepaid Inpatient Health Plans and Coordinating Agencies), Nursing Facilities, Program of All Inclusive Care for the Elderly (PACE), MI Choice Waiver, Local Health Departments, Area Agencies on Aging	7/1/09 Information incorporated into the Hospital and the Nursing Facility Coverages Chapters.
5/1/09	MSA 09-23	Dental Periodicity Schedule	Dentists and Dental Clinics	7/1/09 Information incorporated into the Dental and Practitioner Chapters and the Directory Appendix.
5/1/09	MSA 09-22	Establishment of Consent Form Submission and New Documentation Categories through Claim Documentation EZ Link	Practitioners, Mental Health and Substance Abuse, Community Mental Health Services Program, Chiropractors, Dentists, Ambulance, Independent Labs, Medical Suppliers, Orthotists/Prosthetists, Vision, Hearing and Speech Centers, Hearing Aid Dealers, Family Planning Clinics, Maternal Infant Health Program, Private Duty Nursing, School Based Services, Hospitals, Home Health, Hospice, Nursing Facilities, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, and Local Health Departments	7/1/09 Information incorporated into the Billing & Reimbursement for Dental Providers, the Billing & Reimbursement for Institutional Providers, and the Billing & Reimbursement for Professionals Chapters, the Directory Appendix and the Forms Appendix.
5/1/09	MSA 09-21	Revisions to the School Based Services and School Based Services Random Moment Time Study Medicaid Provider Manual Chapters	School Based Services Providers	Bulletin rescinded – see Bulletin MSA 09-34

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5/1/09	MSA 09-20	Medicare Enrollment for Providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies Reminder	Medical Suppliers, Cochlear Implant Manufacturers	7/1/09 Information incorporated into the General Information for Providers and the Medical Supplier Chapters.
4/21/09	MSA 09-19	$5 Million Disproportionate Share Hospital (DSH) Pool	Hospitals	
4/1/09	MSA 09-18	Prior Authorization of Children's Waiver Services – Environmental Accessibility Adaptations and Specialized Medical Equipment and Supplies	Prepaid Inpatient Health Plans/Community Mental Health Services Programs	7/1/09 Information incorporated into the Mental Health/Substance Abuse Chapter and the Directory Appendix.
4/1/09	MSA 09-17	Pharmacy Beneficiary Eligibility Verification	Pharmacies	7/1/09 Information incorporated into the Directory Appendix.
2/09	MSA 09-16	Sanctioned Providers Update	All Providers	Information incorporated into the Sanctioned Providers List maintained on the MDCH website.
3/1/09	MSA 09-15	Healthcare Common Procedure Coding System (HCPCS) U4 Modifier for Certain Durable Medical Equipment for Beneficiaries Under the Age of 21; Coverage of New HCPCS Procedure Code – K0739	Medical Suppliers	7/1/09 Information incorporated into the Billing & Reimbursement for Professionals Chapter. Information added to databases at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Medical Suppliers/Orthotists/Prosthetists, DME Dealers
3/1/09	MSA 09-13	Updates to Medicaid Provider Manual	All Providers	4/1/09 Information incorporated throughout the Manual, as appropriate. MDCH website updated, as appropriate.

Supplemental Bulletin List

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
3/1/09	MSA 09-12	Change in Standard Dispensing Fee Reimbursement	Pharmacy	MDCH Pharmacy Drug Dispensing Fees updated to the website www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Pharmacy
3/1/09	MSA 09-11	Correction to Bulletin MSA 09-03	Hearing Aid Dealers, Audiologists/Hearing Centers, Outpatient Hospitals, Practitioners, Medicaid Health Plans	4/1/09 Information incorporated into the Hearing Aid Dealers Chapter.
3/1/09	MSA 09-10	Adult Benefits Waiver Enrollment	All Providers	Bulletin transmits open enrollment of 3/1/09 - 5/31/09.
3/1/09	MSA 09-09	Change in Billing and Reimbursement Policy for Occupational Therapy, Physical Therapy, and Speech-Language Therapy	Practitioners (MDs, DOs, Nurse Practitioners, Physical Therapists), Outpatient Hospitals, Outpatient Rehabilitative Facilities, Mental Health and Substance Abuse	4/1/09 Information incorporated into the Billing & Reimbursement for Institutional Providers Chapter.
2/11/09	MSA 09-08	Fiscal Year 2009 Outpatient Uncompensated Care Disproportionate Share Hospital (DSH) Pool	Hospitals	4/1/09 Information incorporated into the Hospital Chapter (Hospital Reimbursement Appendix).
2/1/09	MSA 09-07	Clarifications, Revisions, and Provider Reinstatement	School Based Services	4/1/09 Information incorporated into the School Based Services Chapter.
2/1/09	MSA 09-06	Medicaid Access to Care Initiative (MACI) Payment Schedule	Hospitals, Medicaid Health Plans	Bulletin issued to retract bulletin MSA 08-16; no changes to manual required.
1/1/09	MSA 09-05	MIHP and MHP Care Coordination Agreement	Maternal Infant Health Program, Medicaid Health Plans	4/1/09 Information incorporated into the Maternal Infant Health Program Chapter, the Medicaid Health Plans Chapter, the Acronym Appendix, and the Forms Appendix.

Supplemental Bulletin List

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
1/1/09	MSA 09-04	Eligibility Verification System (EVS) – Automated Voice Response System (AVRS) Fee	All Providers	4/1/09 Information incorporated into the Beneficiary Eligibility Chapter and the Directory Appendix.
1/1/09	MSA 09-03	Volume Purchase Contract for Hearing Aids	Hearing Aid Dealers, Audiologists/Hearing Centers, Outpatient Hospitals, Practitioners, Medicaid Health Plans	4/1/09 Information incorporated into the Hearing Aid Dealers Chapter and the Hearing Services Chapter. Information added to the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Hearing Aid Services
1/09	MSA 09-02	Sanctioned Providers Update	All Providers	Information incorporated into the Sanctioned Providers List maintained on the MDCH website.
12/1/08	MSA 08-57	Diagnosis Related Group (DRG) Grouper Update, DRG Rate Update, and Per Diem Rate Update	Hospitals, Medicaid Health Plans	4/1/09 Information incorporated into the Hospital Chapter (Hospital Reimbursement Appendix).