MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 10-55

Distribution: All Providers

Issued: December 1, 2010

Subject: Updates to the Medicaid Provider Manual; Physicians/Practitioners and Medical Clinics Database; Correction to Bulletin MSA 10-20; Patient Protection and Affordable Care Act (ACA) Compliance; Habilitation/Supports Waiver (HSW) New Service

Effective: As Indicated

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 January 2011 quarterly update of the Michigan Medicaid Provider Manual. The Manual is maintained on the MDCH website at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual. A compact disc (CD) version of the Manual is available to enrolled providers upon request.

The January 2011 version of the Manual does not highlight changes made during the past year (2010). However, consistent with previous quarterly manual updates, tables attached to this bulletin describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change. Subsequent changes made for the April, July, and October 2011 versions of the manual will be highlighted within the text of the on-line manual.

Physicians/Practitioners and Medical Clinics Database

Effective January 1, 2011, MDCH will publish a subset of the Physicians/Practitioners and Medical Clinics Database codes and their fee screens. The new subset of codes is titled Physician-Administered Drugs and Biologicals.

Fee screens and coverage parameters are located on the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Correction to Bulletin MSA 10-20

Bulletin MSA 10-20; Registered Dental Hygienists as an Enrolled Medicaid Provider was issued on November 12, 2010. Affected providers (Dentists and Dental Clinics) should note the following correction. In the section titled "National Provider Identification (NPI) and Billing Information", first paragraph, the second sentence should read: "Effective for dates of service on and after **January 1, 2011**, the billing provider can submit claims for services with the RDH as the rendering/servicing provider.

Patient Protection and ACA Compliance

On March 23, 2010, the Patient Protection and ACA was signed into law. While the Medical Services Administration (MSA) is currently in compliance with several sections of the ACA, MSA is reviewing the law and working with the Federal government to achieve compliance as new Federal guidance is issued. MSA will utilize the policy promulgation process as necessary to provide notification of required changes to the Medicaid Program.

Habilitation/Supports Waiver for Persons with Developmental Disabilities

Goods and Services (New Service Effective October 1, 2010)

The purpose of Goods and Services is to promote individual control over, and flexible use of, the individual budget by the HSW beneficiary using arrangements that support self-determination and facilitate creative use of funds to accomplish the goals identified in the individual plan of services (IPOS) through achieving better value or an improved outcome. Goods and services must increase independence, facilitate productivity, or promote community inclusion and substitute for human assistance (such as personal care in the Medicaid State Plan and community living supports and other one-to-one support as described in the HSW or §1915(b)(3) Additional Service definitions) to the extent that individual budget expenditures would otherwise be made for the human assistance.

A Goods and Services item must be identified using a person-centered planning process, meet medical necessity criteria, and be documented in the IPOS. Purchase of a warranty may be included when it is available for the item and is financially reasonable.

Goods and Services are available only to individuals participating in arrangements of self-determination whose individual budget is lodged with a fiscal intermediary.

This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle.

Manual Maintenance

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

Questions

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

Requests for the Michigan Medicaid Provider Manual on compact disc (CD) should contain the provider's name, National Provider Identifier (NPI) number, mailing address, and telephone number and be submitted:

By mail to: MDCH/Medicaid Program Policy Division, PO Box 30479, Lansing, MI 48909
By e-mail to: MSA-Forms@Michigan.gov
By fax to: 517-335-5136

Approved

Stephen Fitton, Director
Medical Services Administration

Michigan Department of Community Health

Medicaid Provider Manual
January 2011 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		References to "Health Care Financing Administration Procedure Coding System" were revised to read "Healthcare Common Procedure Coding System"	Consistency of wording in Manual
		General formatting edits were made. These edits included removing hyphens from words such as coinsurance and copayment for consistency and improving accuracy of search results.	General editing
General Information for Providers	11.3 Billing Limitation	In the 1st paragraph, the 1st sentence was corrected to read: Each claim received by MDCH receives a unique identifier called a Transaction Control Number (TCN).	Typo correction
	11.4 Provider Returning Overpayments (new subsection; following subsections re-numbered)	New subsection language reads as follows: Medicaid providers performing self audits may discover an overpayment situation and wish to return the Medicaid overpayment to MDCH. This process should only be used when the provider is unable to claim adjust or it is not practical to claim adjust. Sending in a check will not correct the underlying claim(s) data. Providers must: • Document why the money is being returned (i.e., provider self audit) and identify provider NPI information, address, dates of service, and specialty area (i.e., durable medical items, pharmacy, physician practice, hospital, etc.) and include a basic information letter. • Attach an excel spreadsheet document with the Tax ID, billing NPIs, and associated amounts (if multiple IDs exist for the entity) for the MDCH Accounting Office to apply credit to. • Make check payable to "State of Michigan" and mail to the MDCH/Cashier's Unit - Attn: Bureau of Finance-MCU. (Refer to the Directory Appendix for contact information.)	General information; added in response to provider inquiry
Beneficiary Eligibility	2.1 Benefit Plans	In the table, information under "Included In: HIPAA 271 and EE Subsystem" was revised to read "Yes" for the following Benefit Plan IDs: CMH, CSHCS-MH, PIHP, & SA	These Benefit Plan IDs were added to the CHAMPS eligibility response and 271 transaction response.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
	3.3 Eligibility Verification for Dates of Service Over 12 Months Old	The 2nd sentence was revised to read: An exception is allowed for Hospital providers (Enrollment Type: FAO) to submit DOS older than 12 months for inpatient related services only to complete Medicare DSH audits. Providers must complete the DSH question under the "Manage Provider Checklist" page in the CHAMPS-PE Subsystem and receive approval from MDCH. The last sentence was revised to read: There may be a transaction fee charged to the requester for these DSH inquiries.	Update
Billing & Reimbursement for Institutional Providers	Section 5 - Hospital Claim Completion - Inpatient	The following was added at the end of the 1st paragraph: The MDCH website contains additional billing information (i.e., MDCH Institutional Billing Resource document). (Refer to the Directory Appendix for website information.)	General information
	5.1.A. Intensive Care	The paragraph was revised to read: Refer to the NUBC Manual for the specific cost center for a specific type of intensive care unit and the definitions and report the most appropriate revenue code. The MDCH website contains additional billing information (i.e., MDCH Institutional Billing Resource document). (Refer to the Directory Appendix for website information.)	General update
	5.3 Pre-Admission and Certification Evaluation Review	In the 4th paragraph, in the table under "Readmission within 15 days to the Same Hospital (Related Admission)", the 1st bullet point was revised to read: • NUBC revenue code 0180 (Leave of Absence (LOA)) is used for the days the beneficiary was not in the hospital.	General update
	5.6 Telemedicine	The 1st sentence was revised to read: To be reimbursed for the originating site facility fee, the hospital must bill the appropriate telemedicine NUBC revenue code with the appropriate telemedicine CPT/HCPCS procedure code and modifier.	Clarification

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
	Section 6 - Hospital Claim Completion - Outpatient	The following text was added: Information in this section should be used in conjunction with the National Uniform Billing Committee (NUBC) Manual when preparing Hospital claims. The MDCH website contains additional billing information (i.e., MDCH Institutional Billing Resource document). (Refer to the Directory Appendix for website information.)	Clarification
	6.2.A. Billing Instructions for Hospital-Owned Ambulances	The 1st bullet point was revised to read: • The appropriate NUBC Ambulance revenue code with the appropriate MDCH covered ambulance CPT/HCPCS procedure code(s) must be reported for each ambulance trip on the individual service line(s).	Clarification
	6.4 Childbirth Education	Subsection was re-named "Beneficiary Education." "Childbirth Education" is now identified as subsection 6.4.A.	Subsection re-named to better accommodate information
	6.4.B. Kidney Disease Education (KDE) (new subsection)	New subsection text reads: MDCH follows Medicare's billing and reimbursement requirements for covered Kidney Disease Education (KDE) services. • Bill the appropriate NUBC Revenue Code • Bill the appropriate CPT/HCPCS code for KDE • Bill the appropriate diagnosis code	General update/clarification
	6.7 Donor Searches	The 2nd bullet point was revised to read: • The appropriate NUBC revenue code should be used with the appropriate CPT/HCPCS procedure code. The MDCH website contains additional billing information (i.e., MDCH Institutional Billing Resource document). (Refer to the Directory Appendix for website information.)	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
	6.8 Drugs Administered on Premises	Paragraph text was revised to read: Medicaid does not cover the NUBC revenue code for self-administered drugs. Refer to the Revenue Code Requirements Table posted on the MDCH website. (Refer to the Directory Appendix for website information.)	Clarification
	6.9 Emergency Department Services	In the chart, under "EMTALA Screen", the 1st sentence was revised to read: The hospital must bill the appropriate NUBC Emergency Department (ED) revenue code with the appropriate ED Evaluation and Management (E&M) code/CPT/HCPCS procedure code when billing the EMTALA screen without follow-up treatment/stabilization services. Under "Emergency Department Non-Emergency Treatment Services", the 1st bullet point was revised to read: • Hospitals must bill the appropriate NUBC ED revenue code.	Clarification
	6.13 Labor and Delivery Room	In the 2nd paragraph, the 1st sentence was revised to read: False labor charges for a room used by a beneficiary in active labor who does not progress to delivery must be billed using the appropriate NUBC revenue code (i.e., Other Labor Room/Delivery) and the appropriate CPT/HCPCS procedure code. In the 2nd paragraph, the 2nd bullet point was revised to read: • No other room charges may be billed with the NUBC Revenue Code (Other Labor Room/Delivery) for the same date of service. The last paragraph was revised to read: Refer to the MDCH Institutional Billing Resource document (posted on the MDCH website) for billing updates and additional information. (Refer to the Directory Appendix for website information.)	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
	6.17 Rehabilitation Services (new subsection; following subsections re-numbered)	New subsection text reads: MDCH follows Medicare's billing requirements for Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), and Pulmonary Rehabilitation (PR). Hospitals must bill appropriately following Medicare's billing guidelines.	General update/clarification
	6.17 Self-Care Dialysis Training	In the 2nd paragraph, the 1st bullet point was revised to read: • Report the appropriate CPT/HCPCS procedure code for dialysis patient training, complete course. In the 3rd paragraph, the 1st bullet point was revised to read: • Report each session separately using the appropriate CPT/HCPCS procedure code for dialysis patient training, per session. In the 3rd paragraph, the following bullet point was added: Report each session using the appropriate CPT/HCPCS procedure code for dialysis patient training, course not completed, per training session.	Clarification
Children's Special Health Care Services	Throughout the chapter	References to "legal guardian" were revised to read "court-appointed guardian."	Clarification (updated) language
Hospice	6.3.B. Co-Payments	Subsection title was revised to read: "Coinsurance"	Correction
	6.4 Reimbursement Limits	The 1st paragraph was removed.	Correction; not applicable to Michigan Medicaid

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.7.C. Kidney Disease Education (KDE) Services (new subsection)	New subsection text reads: MDCH reimburses for kidney disease education (KDE) of beneficiaries diagnosed with stage IV chronic kidney disease (CKD). If KDE is done in the outpatient hospital (OPH), only the OPH or physician (qualified person) may bill for services on the same day, same beneficiary. MDCH follows Medicare's coverage and reimbursement policies related to KDE.	Addition of general information
	3.26 Rehabilitation Services (new subsection; following subsections re-numbered)	New subsection text reads: MDCH follows Medicare's coverage and reimbursement policies related to Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), and Pulmonary Rehabilitation (PR). MDCH reimburses covered services for CR and ICR services for beneficiaries with chronic and specific medical (diagnosis code specific) conditions, respectively. Hospitals and physicians, any combination of services, may provide the rehabilitation sessions. ICR programs must be approved and certified. MDCH reimburses covered services for PR for beneficiaries with obstructive pulmonary disease and other specific medical diagnosis.	Addition of general information
Hospital Reimbursement Appendix	7.3.A. Government Provider DSH Pool	In the 1st paragraph, the 3rd sentence was revised to read: ... for fiscal year 2008, and $73,117,228 for fiscal year 2009 and each subsequent fiscal year ...	Update per CMS approval of SPA 09-11
	7.7.A. Children's Hospital Pool	The 1st paragraph was revised to read: Qualifying children's hospitals will share annually in an outpatient adjustor pool of $521,300.	Update per CMS approval of SPA 09-12
Mental Health/ Substance Abuse	Throughout the chapter	References to "supports broker" were revised to read "independent supports broker."	Update

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Mental Health/ Substance Abuse	3.3 Behavior Treatment Review	In the 2nd paragraph, the 3rd sentence was revised to read: ... by a specially constituted body comprised of at least three individuals, one of whom shall be a fully- or limited-licensed psychologist and one of whom shall be a licensed physician.	Update and clarification
Mental Health/ Substance Abuse	Section 15 - Habilitation/Supports Waiver for Persons with Developmental Disabilities	The following was added as the last paragraph: Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.	Change is a result of CMS's approval of the waiver renewal effective 10/1/2010.
	15.1 Waiver Supports and Services	Text for "Chore Services" was removed.	Change is a result of CMS's approval of the waiver renewal effective 10/1/2010. Activities performed under this coverage are now included in Community Living Supports.
	15.1 Waiver Supports and Services	Under "Community Living Supports (CLS)": In the 1st paragraph, the first two sentences were revised to read: Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other ...	Clarification to assist agencies to better understand the boundaries between state plan personal care (Home Help) and HSW personal care (CLS)

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		In the 1st bullet point, the asterisk (*) was removed. In the 1st bullet point, the 2nd sub-bullet was revised to read: ➢ ... care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services); In the 2nd bullet point, the 7th sub-bullet was revised to read: ➢ Acquiring goods and/or services other than those ... The last paragraph and footnote (*) were removed and replaced with: For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed DHS's allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings. If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help and, if necessary, Expanded Home Help from DHS. CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a DHS decision.	

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CHAPTER	SECTION	CHANGE	COMMENT
	15.1 Waiver Supports and Services	Under "Enhanced Medical Equipment and Supplies", the following was added at the end of the 7th paragraph: Eyeglasses, hearing aids, and dentures are not covered. The following was added after the last paragraph: The PIHP must assure that all applicable private insurance, Medicare and/or Medicaid requirements for the procurement of durable medical equipment and supplies have been met. The PIHP may not use the waiver service to purchase equipment or supplies that would have been covered by another program if the program's rules were followed, including using providers who participate with that program.	Clarification
	15.1 Waiver Supports and Services	Under "Enhanced Pharmacy", the following was added after the last paragraph: HSW funds cannot be used to pay for copays for other prescription plans the beneficiary may have.	Clarification
	15.1 Waiver Supports and Services	Under "Environmental Modifications", in the 2nd paragraph, the following was added as a 5th bullet point: • Environmental control devices that replace the need for paid staff and increase the beneficiary's ability to live independently, such as automatic door openers The 3rd paragraph was revised to read: Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of the beneficiary, and are not of direct medical or remedial benefit. Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (except under exceptions noted in the service definition), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs. The HSW does not cover construction costs in a new home or additions to a home purchased after the beneficiary is enrolled in the waiver.	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
		In the 4th paragraph, the following text was added after the 3rd sentence: An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use, or function of a room within the home or finding alternative housing. Assessments and specialized training needed in conjunction with the use of such environmental modifications are included as a part of the cost of the service. The following was added at the end of the 5th paragraph: Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a beneficiary's home. In the 7th paragraph, the 1st sentence was deleted. The 10th paragraph was revised to read: Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner, the beneficiary, and the PIHP must specify any requirements for restoration of the property to its original condition if the occupant moves. If a beneficiary or his family purchases or builds a home while receiving waiver services, it is the beneficiary's or family's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. HSW funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to the plan (e.g., roll-in shower), the HSW may be used to fund the difference between the standard fixture and the modification required to accommodate the beneficiary's need. The last paragraph was removed.	
	15.1 Waiver Supports and Services	Under "Personal Emergency Response Systems (PERS)", the following was added at the end of the 1st paragraph: The response center is staffed by trained professionals. This service includes a one-time installation and up to twelve monthly monitoring services per year.	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
	15.1 Waiver Supports and Services	Under "Prevocational Services", the first two paragraphs were removed and replaced with the following text: Prevocational services involve the provision of learning and work experiences where a beneficiary can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. Services are expected to occur over a defined period of time and provided in sufficient amount and scope to achieve the outcome, as determined by the beneficiary and his/her care planning team in the ongoing person-centered planning process. Services are expected to specifically involve strategies that enhance a beneficiary's employability in integrated, community settings. Competitive employment or supported employment are considered successful outcomes of prevocational services. However, participation in prevocational services is not a required prerequisite for competitive employment or receiving supported employment services. Prevocational services should enable each beneficiary to attain the highest possible wage and work which is in the most integrated setting and matched to the beneficiary's interests, strengths, priorities, abilities, and capabilities. Services are intended to develop and teach general skills that lead to employment including, but not limited to: • ability to communicate effectively with supervisors, co-workers and customers; • generally accepted community workplace conduct and dress; • ability to follow directions; • ability to attend to tasks; • workplace problem solving skills and strategies; • general workplace safety; and • mobility training. Support of employment outcomes is a part of the person-centered planning process and emphasizes informed consumer choice. This process specifies the beneficiary's personal outcomes toward a goal of productivity, identifies the services and items, including prevocational services and other employment-related services that advance achievement of the beneficiary's outcomes, and addresses the alternatives that are effective in supporting his or her outcomes. From the alternatives, the beneficiary selects the most cost-effective approach that will help him or her achieve the outcome.	Clarification

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		Beneficiaries who receive prevocational services during some days or parts of days may also receive other waiver services, such as supported employment, out-of-home non-vocational habilitation, or community living supports, at other times. Beneficiaries who are still attending school may receive prevocational training and other work-related transition services through the school system and may also participate in prevocational services designed to complement and reinforce the skills being learned in the school program during portions of their day that are not the educational system's responsibility, e.g., after school or on weekends and school vacations. Prevocational services may be provided in a variety of community locations. Beneficiaries participating in prevocational services may be compensated in accordance with applicable Federal laws and regulations, but the provision of prevocational services is intended to lead to a permanent integrated employment situation. The following was inserted after the 3rd paragraph: Prevocational services may be provided to supplement, but may not duplicate, services provided under supported employment or out-of-home non-vocational habilitation services. Coordination with the beneficiary's school is necessary to assure that prevocational services provided in the waiver do not duplicate or supplant transition services that are the responsibility of the educational program. Transportation provided between the beneficiary's place of residence and the site of the prevocational services, or between habilitation sites, is included as part of the prevocational and/or habilitation services. Assistance with personal care or other activities of daily living that are provided to a beneficiary during the receipt of prevocational services may be included as part of prevocational services or may be provided as a separate State Plan Home Help service or community living supports service under the waiver, but the same activity cannot be reported as being provided to more than one service. Only activities that contribute to the beneficiary's work experience, work skills, or work-related knowledge can be included in prevocational services.	

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CHAPTER	SECTION	CHANGE	COMMENT
	15.1 Waiver Supports and Services	Under "Private Duty Nursing (PDN)", the 1st paragraph was revised to read: Private Duty Nursing (PDN) services are skilled nursing interventions provided to individuals age 21 and older, up to a maximum of 16 hours per day, to meet an individual's health needs that are directly related to his developmental disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the written health care plan which is part of the beneficiary's individual plan of services (IPOS). The individual receiving PDN must also require at least one of the following habilitative services, whether being provided by natural supports or through the waiver. The 2nd paragraph was revised to read: To be determined eligible for PDN services, the PIHP must find that the beneficiary meets Medical Criteria I as well as Medical Criteria III, or meets Medical Criteria II as well as Medical Criteria III. Regardless of whether the beneficiary meets Medical Criteria I or II, the beneficiary must also meet Medical Criteria III.	Clarification
	15.1 Waiver Supports and Services	Under "Medical Criteria I", bullet points were revised to read: • (1st bullet point) Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate-dependent respiration (e.g., some models of Bi-PAP); or • (2nd bullet point) Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or • (5th bullet point) Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below. Under "Medical Criteria III", the 3rd bullet point was revised to read**:** • "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse.	

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		Skilled nursing care includes, but is not limited to: ➢ performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions; ➢ managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the beneficiary four or more hours per day; ➢ deep oral (past the tonsils) or tracheostomy suctioning; ➢ injections when there is a regular or predicted schedule, or prn injections that are required at least once per month (insulin administration is not considered a skilled nursing intervention); ➢ nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; ➢ total parenteral nutrition delivered via a central line and care of the central line; ➢ continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below; ➢ monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.	

TECHNICAL CHANGES*

<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td></td><td>15.1 Waiver Supports and Services</td><td>
Under "Medical Criteria III", the following was added after the 2nd paragraph:

Once the Medical Criteria eligibility for PDN has been established, and as part of determining the amount of PDN a beneficiary is eligible for, the Intensity of Care category must be determined. This is a clinical judgment based on the following factors:
• The beneficiary's medical condition;
• The type and frequency of needed nursing assessments, judgments and interventions; and
• The impact of delayed nursing interventions.

Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary but do not determine the amount of hours of nursing for which the beneficiary is eligible.
<table>
<tr><th>High Category</th><th>Medium Category</th><th>Low Category</th></tr>
<tr><td>Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period when delayed nursing interventions could result in further deterioration of health status, in loss of function, death, or in acceleration of the chronic condition.</td><td>Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least one time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function, death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care.</td><td>Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.</td></tr>
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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		The amount of PDN (i.e., the number of hours that can be authorized for a beneficiary) is determined through the person-centered planning process to address the individual's unique needs and circumstances. Factors to be considered should include the beneficiary's care needs which establish medical necessity for PDN; the beneficiary's and family's circumstances (e.g., the availability of natural supports); and other resources for daily care (e.g., private health insurance, trusts, bequests). Although the person-centered planning process is used to determine the exact amount of PDN specified in the IPOS, in general, a beneficiary who has Low Category PDN needs would require eight or fewer hours per day, a beneficiary who has Medium Category PDN needs would require 12 or fewer hours per day, and a beneficiary who has High Category PDN needs would require 16 or fewer hours per day. The following was inserted after the 5th paragraph: If a beneficiary is attending school and the Individualized Educational Plan (IEP) identifies the need for PDN during transportation to and from school and/or in the classroom, the school is responsible for providing PDN during school hours. The following was inserted as the last paragraph (prior to the textbox): In the event that a transition plan has been developed wherein PDN services are to be reduced or eliminated based on a determination of medical necessity, the PIHP may provide PDN for a period of time (not to exceed three months) for the purpose of training the CLS or respite aides or family and assuring a smooth transition. In those cases, the transition plan, including amount, scope, frequency and duration of the training by nurses to aides, must be documented in the IPOS. A transition process is not intended to provide two-to-one (nurse and aide) staffing for any purpose other than for training (with limitations on duration and frequency noted in the IPOS) while the aide or family member becomes familiar with the beneficiary's care needs. This transition period is only permitted when it has been determined that PDN is not medically necessary and the beneficiary's care needs can be met by a trained CLS or respite aide.	

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
	15.1 Waiver Supports and Services	Under "Respite Care", the 1st and 2nd paragraphs were revised to read: Respite care services are provided to a waiver eligible beneficiary on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. • "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations). • "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with periods in between. • "Primary" caregivers are typically the same people who provide at least some unpaid supports daily. • "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school). Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work full-time. In those cases, community living supports or other services of paid support or training staff should be used. The beneficiary's record must clearly differentiate respite hours from community living support services. Decisions about the methods and amounts of respite are decided during the person-centered planning process. Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver.	Clarification

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
	15.1 Waiver Supports and Services	Under "Supports Coordination", the 1st paragraph was revised to read: Supports coordination works with the waiver beneficiary to assure all necessary supports and services are provided to enable the beneficiary to achieve community inclusion and participation, productivity, and independence in home- and community-based settings. Without the supports and services, the beneficiary would otherwise require the level of care services provided in an ICF/MR. Supports coordination involves the waiver beneficiary and others identified by the beneficiary (i.e., family member(s)) in developing a written individual plan of services (IPOS) through the person-centered planning process. The waiver beneficiary may choose to work with a supports coordinator through the provider agency, an independent supports coordinator, a supports coordinator assistant, or an independent supports broker. Functions performed by a supports coordinator, supports coordinator assistant, or independent supports broker include an assurance of the following: In the 1st paragraph, the first three bullet points were revised to read: • Planning and/or facilitating planning using person-centered principles. This function may be delegated to an independent facilitator chosen by the beneficiary. • Developing an IPOS using the person-centered planning process, including revisions to the IPOS at the beneficiary's request or as the beneficiary's changing circumstances may warrant. • Linking to, coordinating with, follow-up of, and advocacy with all supports and services, including the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers. and the last bullet point was deleted. A new bullet point was added which reads: • Monitoring of Habilitation Supports Waiver and other mental health services	Clarification

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		In the 2nd paragraph, the 1st sentence was revised to read: The role of the supports coordinator assistant is to perform the functions listed above, as they are needed, when the beneficiary selects an assistant in lieu of a supports coordinator. In the 3rd paragraph, the 1st sentence was revised to read: The beneficiary may select an independent supports broker to perform supports coordination functions. The following was inserted as a new 5th paragraph: Many beneficiaries choose an independent supports broker rather than traditional case management services or supports coordination provided directly by a supports coordinator. If a beneficiary does not want case management or supports coordination services, the PIHP will assist the beneficiary to identify who will assist him in performing each of the functions, including the use of natural supports or other qualified providers, to assure the supports coordination functions are provided. The IPOS must reflect the beneficiary's choices, the responsible person(s) for each of the functions listed in this section, and the frequency at which each will occur. In the 5th paragraph, the following was added as the 1st sentence: When the beneficiary chooses a supports coordinator assistant, an independent supports broker, or a natural support to perform any of the functions, the IPOS must clearly identify which functions are the responsibility of the supports coordinator, the supports coordinator assistant, the independent supports broker or the natural support. In the 6th paragraph, the 2nd sentence was revised to read: Supports coordinators, supports coordinator assistants, or independent supports brokers will work closely with the beneficiary to assure his ongoing satisfaction with the process and outcomes of the supports, services, and available resources.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		In the 7th paragraph, the asterisk (*) was removed from the 4th bullet point. The 8th paragraph was revised to read: Additionally, the supports coordinator, supports coordinator assistant, or independent supports broker coordinates with, and provides information as needed to, the qualified mental retardation professional (QMRP) … In the 9th paragraph, the following text was inserted after the 1st sentence: Supports coordination does not include any activities defined as Out-of-Home Non-Vocational Habilitation, Prevocational Services, Supported Employment, or CLS. In the 9th paragraph, the 2nd sentence was revised to read: Supports coordinators, supports coordinator assistants, and independent supports brokers are prohibited…	
	15.1 Waiver Supports and Services	Under "Supported Employment", in the 2nd paragraph, the following was added to the end of the last sentence: … or for any services that are the responsibility of another agency, such as Michigan Rehabilitation Services. In the 5th paragraph, the following was added at the end: Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for work activity or supported employment services provided by MRS. Information must be updated when MRS eligibility conditions change.	Clarification
	15.2.A. Supports Coordinator Qualifications	Subsection text was revised to read: The Supports Coordinator must be: • a QMRP • Selected by the beneficiary	Clarification

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
	15.2.B. Trained Supports Coordinator Assistant Qualifications	A 3rd bullet point was added; reads: • Selected by the beneficiary	Clarification
	15.2.C. Aide Qualifications	The 4th bullet point was revised to read: • In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, not an illegal alien). A 6th bullet point was added; reads: • Has received training in the beneficiary's IPOS	Clarification and general information
	15.2.D. Supports Broker Qualifications	Subsection title was revised to read: Independent Supports Broker Qualifications	Update
Nursing Facility Coverages	7.3 Minimum Data Set (MDS)	In the 1st paragraph, the 2nd sentence was revised to read: "... which includes the MDS, Care Area Assessment (CAA) process and utilization guidelines, is mandatory.	Changed to coincide with current MDS language.
Nursing Facility Cost Reporting & Reimbursement Appendix	4.3 Cost Report Requirements	In the 1st paragraph, the last sentence was revised to read: The CD has the applicable electronic cost report template, completion instructions, construction cost index for asset acquisitions, and other pertinent information.	General update
	9.4.A.1. Capitalized Asset Acquisition Costs	In the 8th paragraph, the 5th and 6th sentences were revised to read: The derived value calculation is made by applying a construction cost index (exclusive of the annual obsolescence adjustment) to the value of the new asset item cost, then subtracting the derived value from the previous capital asset cost data historical cost for that original acquisition year. An electronic copy of the annual economic index compilation and the derived application process used for nursing facility cost reporting can be accessed on the MDCH website.	General update

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
	10.3.B.1. Asset Value Update Factor	The 2nd sentence was revised to read: Land improvements, buildings, building improvements, and fixed building equipment are updated using a construction cost index for steel frame buildings in the central United States from the fiscal year the asset was brought …	General update
	10.3.B.5. Class I Nursing Facility Current Asset Value Limit Per Bed	In the 1st paragraph, the 3rd sentence was revised to read: The historical costs are updated through 1983 using the U.S. Department of Commerce Composite Construction Index, and annual updates after 1983 are made using a construction cost index for steel frame buildings.	General update
Pharmacy	1.1 MDCH Pharmacy Benefits Manager and Other Vendor Contractors	In the 1st paragraph, the 2nd sentence was revised to read: …, provider enrollment, provider information lines, and Maximum Allowable Cost (MAC) rate setting.	PBM no longer offers provider audit services
	1.2 Definitions	Revision of "Labeler" to read: Any firm that manufactures (including repackers or relabelers) or distributes (under its own name) the drug. Addition of: Pharmacy and Therapeutics (P&T) Committee – An advisory committee to MDCH on issues affecting prescription drug coverage for its various health care programs. The committee recommends guidelines for prescription drugs covered in its various health care programs.	General information
	1.7 Medicaid Health Plans and ABW County Health Plans	The order of the first three paragraphs was revised: • Paragraph #1 is now paragraph #2. • Paragraph #2 is now paragraph #3. • Paragraph #3 is now paragraph #1.	Improve order of information

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	1.7.A. Carve-Out Exceptions (new subsection)	New subsection text reads: Select drugs and classes may be carved-out from the respective health plan's reimbursement and paid Medicaid Fee For Service. (Refer to the PBM website listed in the Directory Appendix for a listing of these drug classes.)	General information
	2.2 Prescriber Identification	The 2nd sentence was removed.	Obsolete information
	Section 6 - General Noncovered Services	In the 2nd paragraph, the 17th bullet point was revised to read: • Drugs past CMS termination dates. (Refer to the Directory Appendix for CMS website information.)	Additional general information
	7.1 Notification of New Outpatient Drugs	The following text was added at the end of the paragraph: New drug products are required to be reviewed by the Pharmacy and Therapeutics (P&T) committee.	Additional general information
	11.1 Days Supply	The 1st sentence was revised to read: Prescription quantities are limited to the quantity specified by the prescriber.	Clarification
	12.2 Common Unit Bases	In the chart: • "Chemstrip BG" was removed • "Zantac" was replaced with "Ranitidine"	Chemstrip BG is covered as a medical supply benefit under DME and is no longer a pharmacy benefit. The brand name for Zantac was replaced with the generic name since the generic drug is MAC priced and is not the brand name.

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CHAPTER	SECTION	CHANGE	COMMENT
	14.7 Infusion Therapy	In the 2nd paragraph, text after the 1st sentence was revised to read: MDCH dispensing fees are posted on the MDCH website. (Refer to the Directory Appendix for website information.)	Update
	Section 19 - Pharmacy Audit and Documentation	The following was added after the 1st paragraph: 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. Inappropriate payments identified in post-payment review are subject to recoupment. Potential fraudulent activities may result in referral to the Michigan Department of Attorney General for investigation. In the chart in the 2nd paragraph: • "Auditing" and accompanying information was removed. • Information for "Drug Rebate" was relocated to "Days Supply." • "Public Health Service and Disproportionate Share Hospitals" and accompanying information was removed. • Addition of "340B Drug Pricing Program." Accompanying text reads: Billing ingredient costs higher than actual acquisition costs for drugs procured under the 340B Drug Pricing Program.	Update
School Based Services Administrative Outreach Program Claims Development	2.12 Claim Certification	Text added as the 2nd paragraph reads: The Electronic Signature Verification Statement (DCH-3890) form must be completed by each provider and submitted to MDCH to certify costs electronically. A copy of the completed DCH-3890 must be kept on file by the provider until the individual signing the certification changes. (Refer to the Forms Appendix for a copy of the form.)	Providers notified via letter L 10-27
School Based Services Random Moment Time Study	8.3 FFS/Direct Medical Summer Quarter Formula and Random Moment Time Study	In the 2nd paragraph, 1st bullet point, the 4th sub-bullet point was revised to read: ➢ Date students return to school through September 30 (summer time study)	Update

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Acronym Appendix		Following acronyms/definitions were added: CAA - Care Area Assessment CKD - Chronic Kidney Disease CR - Cardiac Rehabilitation ICR - Intensive Cardiac Rehabilitation KDE - Kidney Disease Education LOA - Leave of Absence P&T - Pharmacy & Therapeutics PR - Pulmonary Rehabilitation Following acronyms/definitions were removed: RAPS - Resident Assessment Protocols	Update
Directory Appendix	Eligibility Verification	Under "Eligibility Verification for Dates Of Service Over 12 Months - Medicare DSH Audits Only": PHONE # FAX # - information was revised to read: Emdeon: (877) 469-3263 **or** (615) 400-7227 Michigan Public Health Institute (MPHI): (877) 816-0737 MAILING/EMAIL/WEB ADDRESS - information was revised to read: Emdeon: Website: www.emdeon.com E-mail: Product/Sales Information = BusinessServicesSales@emdeon.com E-Mail: Customer Support = customer.service@emdeon.com (to report technical problems)	General update

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CHAPTER	SECTION	CHANGE	COMMENT
		MPHI: Website: HIPAA X12 270/271 Realtime/batch Transaction website = http://mihealth.org/champs/HIPAA_270-271.htm E-mail: MedicaidEligibility@mphi.org INFORMATION AVAILABLE/PURPOSE - text was revised to read: HIPAA X12 270/271 Realtime/batch Transaction for Hospital providers and/or their contracted clearinghouse vendors to verify Medicaid eligibility for Medicare DSH audits. There may be a transaction fee charged to the requester for these inquiries. Hospital providers that contract with clearinghouse vendors to submit/receive their DSH inquiries must have the vendor listed as one of their approved billing agents on CHAMPS (PE Subsystem). Information for clearinghouse vendors that need to enroll on CHAMPS as a billing agent: www.michigan.gov/medicaidproviders >> CHAMPS >> Resources >> Billing Agent (in the row for Provider Quick Reference Guides in the Resources section)	
	Billing Resources	Addition of: Contact/Topic: MDCH Institutional Billing Resource Web Address: www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information (>> "Inpatient Hospital" or "Outpatient") Information Available/Purpose: billing updates	Update
	Claim Submission/Payment	Under " MDCH Cashier's Unit", addition of: Mailing Address: MDCH, Cashier's Unit - Attn.: Bureau of Finance-MCU, 320 S. Walnut St., P.O. Box 30437, Lansing, MI 48909 Information Available/Purpose: Provider returning overpayments	Update
	Provider Resources	Information for "Nursing Facility Level of Care Determination" and "MDS" was relocated to Nursing Facility Resources.	Relocation of information

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
	Nursing Facility Resources	Information for "Nursing Facility Level of Care Determination" and "MDS" was relocated from Provider Resources.	Relocation of information
	Pharmacy Resources	Information added: Contact/Topic: List of Drugs Past CMS Termination Dates Web Address: www.cms.gov/MedicaidDrugRebateProgram >> Drug Product Data	Adds a new resource for drugs past termination dates.
Forms Appendix		Addition of: DCH-3890 Electronic Signature Verification Statement	New form per Letter L 10-27

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Medicaid Provider Manual
January 2011 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 10-55	12/01/2010	Throughout Manual		As noted in two attachments: 1) Bulletins Incorporated and 2) Technical Changes
		Practitioner	4.13.B. Administration of the Injectable	The following was added at the end of the 3rd paragraph: A list of the drugs administered under this policy is maintained on the MDCH website in the Physician-Administered Drugs and Biologicals database. (Refer to the Directory Appendix for website information.)
		Mental Health/ Substance Abuse	15.1 Waiver Supports and Services	A new service was added: Goods and Services New service text reads as follows: The purpose of Goods and Services is to promote individual control over, and flexible use of, the individual budget by the HSW beneficiary using arrangements that support self-determination and facilitate creative use of funds to accomplish the goals identified in the individual plan of services (IPOS) through achieving better value or an improved outcome. Goods and services must increase independence, facilitate productivity, or promote community inclusion and substitute for human assistance (such as personal care in the Medicaid State Plan and community living supports and other one-to-one support as described in the HSW or §1915(b)(3) Additional Service definitions) to the extent that individual budget expenditures would otherwise be made for the human assistance. A Goods and Services item must be identified using a person-centered planning process, meet medical necessity criteria, and be documented in the IPOS. Purchase of a warranty may be included when it is available for the item and is financially reasonable. Goods and Services are available only to individuals participating in arrangements of self-determination whose individual budget is lodged with a fiscal intermediary. This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle.
MSA 10-51	11/01/2010	School Based Services	Throughout the chapter	References to "certified and registered" associated with Occupational Therapy were revised to read "licensed". References to "OTR" and "COTA" were removed.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Acronym Appendix		"OTR" and "COTA" were removed.
MSA 10-50	11/01/2010	School Based Services	1.2 Third Party Liability (new subsection)	Re-insertion of text removed in error. (Following subsections were re-numbered.) Subsection text added: Pursuant to Code of Federal Regulations (CFR) 42 CFR §433.137 through 42 CFR §433.139, Medicaid must be the payor of last resort. This means that all identifiable financial resources must be utilized prior to the expenditure of Medicaid funds. Third Party Liability (TPL) is defined as a payment resource available from a private insurance coverage, public insurance coverage, or other liable third party resource that can be used to offset Medicaid costs. The Medicaid agency must take reasonable measures to identify third parties liable for payment of services. If a third party resource exists, this must be pursued prior to Medicaid funds being utilized. If a Medicaid-eligible child is presently covered by one or more of the above-defined third party liabilities and the school district does not bill the TPL, Medicaid cannot be billed for the medically necessary services. (Refer to the Coordination of Benefits Chapter of this manual for additional information on TPL.)
MSA 10-48	11/01/2010	Pharmacy	1.2 Definitions	The definition for Average Wholesale Price (AWP) was revised to read: The list price published in drug price compendia (e.g., by First DataBank) used to price most pharmacy claims. Definition for Wholesale Acquisition Cost (WAC) was added and reads: The list price determined by a manufacturer for a pharmaceutical sold by a manufacturer to a wholesaler.
		Pharmacy	13.4 Product Cost Payment Limits	In the 1st paragraph, the 2nd sentence was revised to read: …(AWP) minus a discount, the Wholesale Acquisition Cost (WAC) markup, the MAC, or … In the 3rd paragraph, the 1st sentence was revised to read: Medicaid's AWP discount or equivalent WAC markup is posted on the MDCH website.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Acronym Appendix		Addition of: AWP - Average Wholesale Price WAC - Wholesale Acquisition Cost
MSA 10-47	10/05/2010	Children's Special Health Care Services	Table of Contents	The burst box was revised to read: As required by Executive Order 2009-22, effective for dates of service on and after 07/01/2009, the following services are no longer payable for CSHCS clients age 21 and older: Chiropractic, Hearing Aids, and Vision (eyeglasses and associated supplies and services). Refer to the specific chapter of this manual for details. Per Public Act 187 of 2010, effective for dates of service on and after 10/01/2010, low-vision services (including low vision eyeglasses, contact lenses, optical devices, and other related low-vision supplies and services) are reinstated for beneficiaries age 21 and older. Reductions affecting in-state and out-of-state travel, implemented as a result of Public Act 131 of 2009, have been restored effective for dates of service on and after 10/01/2010 as a result of Public Act 187 of 2010.
		Children's Special Health Care Services	Section 9 - Benefits	In the 2nd paragraph, the 1st bullet point was revised to read: • Ambulance
		Children's Special Health Care Services	9.1 Specialty Dental Benefits	The burst box at the beginning of the subsection was removed.
		Children's Special Health Care Services	11.1 In-State Travel	The 1st paragraph was revised to read: Requests for transportation assistance must be made as follows: • Clients who are not covered by Medicaid must request travel assistance from the LHD.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				• Clients who have Medicaid coverage can request travel assistance from the LHD when travel assistance from DHS is unavailable. Travel must be related to the CSHCS qualifying diagnosis. If the request for travel is not related to the CSHCS qualifying diagnosis, but is a Medicaid covered service, the LHD will refer the family to the local DHS for assistance. In the 2nd paragraph, a footnote (*) was added to the 1st bullet point; footnote text reads: *Travel assistance may be authorized for individuals who do not have CSHCS but need travel assistance to participate in a diagnostic evaluation that is performed for the purpose of determining CSHCS eligibility. There must be verification that no other resources are available and the individual is otherwise unable to access the site of the diagnostic evaluation. The following was added as the last paragraph: Reimbursement for CSHCS clients with Medicaid coverage who request in-state travel assistance from their local DHS office is provided in accordance with the Medicaid/DHS transportation policy.
		Children's Special Health Care Services	11.2 Out-of-State Travel	The 1st paragraph was revised to read: Requests for transportation for out-of-state travel assistance must be made as follows: • Clients who are not covered by Medicaid must request travel assistance from the LHD or by calling the CSHCS Family Phone Line. (Refer to the Directory Appendix for contact information.) • Clients who have Medicaid coverage can request travel assistance from the LHD. Travel must be related to the CSHCS qualifying diagnosis. If the request for travel is not related to the CSHCS qualifying diagnosis but is a Medicaid covered service, the LHD will refer the family to the local DHS for assistance.
		Dental	Table of Contents	The burst box was revised to read: Reductions affecting dental services for beneficiaries age 21 and older, implemented as a result of Executive Order 2009-22, have been restored effective for dates of service on and after 10/01/2010 as a result of Public Act 187 of 2010. Reinstated services reflect the level of services available in June 2009.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Federally Qualified Health Centers	Table of Contents	The burst box was revised to read: As required by Executive Order 2009-22, effective for dates of service on and after 07/01/2009, Chiropractic and Vision services (routine eye exams, eyeglasses, contact lenses and other vision supplies) are no longer payable for beneficiaries age 21 and older. Per Public Act 187 of 2010, effective for dates of service on and after 10/01/2010, the following services have been reinstated for beneficiaries age 21 and older: • Dental Services • Low-vision Services (Low-vision Services include low-vision eyeglasses, contact lenses, optical devices, and other related low-vision supplies and services. Refer to the Vision Chapter for low-vision coverage and diagnosis code information.) • Podiatry Services Reinstated services reflect the level of services available in June 2009. Refer to specific chapters for additional information.
		Hospital	3.23.B. Transportation and Lodging	The following was inserted after the 2nd sentence: If the beneficiary has CSHCS-only coverage, they must contact the CSHCS office in the LHD of the county where they reside to make travel arrangements.
		Practitioner	Table of Contents	The burst box was revised to read: Reductions affecting Podiatry services for beneficiaries age 21 and older, implemented as a result of Executive Order 2009-22, have been restored effective for dates of service on and after 10/01/2010 as a result of Public Act 187 of 2010. Reinstated services reflect the level of services available in June 2009.
		Practitioner	13.4 Organ Transplants	In the 2nd paragraph, in the chart under Transportation and Lodging, the following was inserted after the 2nd sentence: If the beneficiary has CSHCS-only coverage, they must contact the CSHCS office in the LHD of the county where they reside to make travel arrangements.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Practitioner	Section 23 - Podiatrist	The burst box was revised to read: Reductions affecting Podiatry services for beneficiaries age 21 and older, implemented as a result of Executive Order 2009-22, have been restored effective for dates of service on and after 10/01/2010 as a result of Public Act 187 of 2010. Reinstated services reflect the level of services available in June 2009.
		Rural Health Clinics	Table of Contents	The burst box was revised to read: As required by Executive Order 2009-22, effective for dates of service on and after 07/01/2009, Chiropractic and Vision services (routine eye exams, eyeglasses, contact lenses and other vision supplies) are no longer payable for beneficiaries age 21 and older. Per Public Act 187 of 2010, effective for dates of service on and after 10/01/2010, the following services have been reinstated for beneficiaries age 21 and older: • Dental Services • Low-vision Services (Low-vision Services include low-vision eyeglasses, contact lenses, optical devices, and other related low-vision supplies and services. Refer to the Vision Chapter for low-vision coverage and diagnosis code information.) • Podiatry Services Reinstated services reflect the level of services available in June 2009. Refer to specific chapters for additional information.
		Vision	Table of Contents	The burst box was revised to read: As required by Executive Order 2009-22, effective for dates of service on and after 07/01/2009, Vision services (routine eye exams, eyeglasses, contact lenses and other vision supplies and services) are no longer payable for beneficiaries age 21 and older. Eye exams related to eye injury or eye disease will be covered. Per Public Act 187 of 2010, effective for dates of service on and after 10/01/2010, low-vision services (including low-vision eyeglasses, contact lenses, optical devices, and other related low-vision supplies and services) are reinstated for beneficiaries age 21 and older.

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Claims for low-vision services must be supported by a diagnosis code (listed in Table 1 below). When billing Current Procedural Terminology (CPT) codes for low-vision services (listed in Table 2 below), one of the diagnosis codes must be designated as the primary diagnosis code on the claim service line.

Table 1
Diagnosis Code for Low-Vision

Code	Description
368.46	homonymous hemianopsia
368.47	heteronymous hemianopsia
369.01	tot impairment-both eyes
369.04	near-tot impair-both eye
369.06	one eye-profound/oth-tot
369.07	one eye-prfnd/oth-nr tot
369.08	profound impair both eye
369.12	one eye-severe/oth-total
369.13	one eye-sev/oth-near tot
369.14	one eye-sev/oth-prfnd
369.16	one eye-moderate/oth-tot
369.17	one eye-mod/oth-near tot
369.18	one eye-mod/oth-profound
369.22	severe impair-both eyes
369.24	one eye-moderate/oth-sev
369.25	moderate impair-both eye

Table 2
CPT Codes for Low-Vision

Code	Description
92081	Visual field examination(s)
92082	Visual field examination(s)
92083	Visual field examination(s)
97112	Neuromuscular reeducation
97530	Therapeutic activities
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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 10-43	10/01/2010	Children's Special Health Care Services	5.1 Financial Determination Process	In the 2nd paragraph, the 2nd bullet point was removed.
		Children's Special Health Care Services	5.3 Payment Agreement	The 4th paragraph was revised to read: Clients who acquire full Medicaid or MIChild coverage after enrollment into CSHCS will be reimbursed in full for any money paid toward the payment agreement that is in place for the current CSHCS coverage period. Unpaid balances may be forgiven and CSHCS coverage continued when the client has acquired full Medicaid or MIChild coverage. Clients can call the local health department or the CSHCS Family Phone Line to request assistance with the CSHCS payment agreement. (Refer to the Directory Appendix for contact information.) The following was added at the end of the last paragraph: When a client acquires Medicaid or MIChild coverage after the client reaches the age of majority, the current payment agreement entered into by the family while the client was a minor does not qualify for forgiveness of balance or return of money. The income of the legally independent client is not assessed for a payment agreement until the client's next CSHCS renewal period.
		Children's Special Health Care Services	Section 8 - Coverage Period	In the 2nd paragraph, the 2nd sentence was revised to read: Those with Medicaid or MIChild are determined complete in ... The following was added as 3rd and 4th paragraphs: CSHCS clients are required to apply for MIChild/Healthy Kids when the Income Review/Payment Agreement (MSA-0738) indicates the client may be eligible for one of these programs based on age, family income, and absence of comprehensive health care coverage (when applicable). The Income Review/Payment Agreement is submitted at the time of the initial CSHCS application or renewal (refer to the Payment Agreement subsection). A CSHCS temporary eligibility period (TEP) of 90 days is activated to allow the family time to complete the MIChild/Healthy Kids application process.

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				Upon notification that the family has completed the MIChild/Healthy Kids application process, CSHCS coverage is extended to complete the full 12-month enrollment period from the initial coverage date (begin date of the TEP), regardless of the MIChild/Healthy Kids eligibility decision. CSHCS coverage terminates at the end of the 90-day TEP if the family fails to submit the application.
		Acronym Appendix		Addition of: TEP - Temporary Eligibility Period
MSA 10-42	10/01/2010	Beneficiary Eligibility	9.1 Enrollment	In the chart, under Excluded Enrollment, the 13th bullet point was revised to read: • Children in child caring institutions
MSA 10-38	9/15/2010	Billing & Reimbursement for Professionals	6.10 Federally Qualified Health Centers (new subsection; following subsections re-numbered)	New subsection text: A Federally Qualified Health Center (FQHC) enrolled with a single billing NPI (representing both the FQHC and Family Planning Clinic) must report the non-individual taxonomy code of 261QF0050X (Family Planning, Non-Surgical) to allow successful adjudication of family planning services. The taxonomy code must be reported at the header level of the claim, along with the billing provider NPI. The taxonomy code must only be reported for family planning services. For non-family planning services, a separate claim must be submitted to MDCH omitting the taxonomy code with the billing provider NPI.
MSA 10-36	9/1/2010	Nursing Facility Coverages	7.3 Minimum Data Set (MDS)	The following was added after the 4th paragraph: NOTE: The Michigan Medicaid MI Choice Waiver Agencies are the designated Local Contact Agency (LCA) relative to Section Q of the MDS. (Refer to the Directory Appendix for contact information.)

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		Directory Appendix	Nursing Facility Resources	Information added: Contact/Topic: Minimum Data Set (MDS) - Section Q - Local Contact Agency (LCA) Web Address: www.michigan.gov/mdch >> Health Care Coverage >> Services for Seniors >> MI Choice Waiver Program Information Available/Purpose: A list of Local Contact Agencies that nursing facilities must contact when residents indicate a desire to return to the community.
MSA 10-35	9/1/2010	Billing & Reimbursement for Institutional Providers	9.1.B. Payment in 15-Minute Increments	Subsection re-named: Payment in One-Hour Increments Subsection text was revised to read: Private duty nursing is prior authorized and paid in one-hour increments. When billing for services, the total number of hours billed (whether with S9123 and/or S9124) must not exceed the total number of hours authorized for that month. Since whole hours of care are authorized, only those hours of care that entail a full hour of care may be billed.
		Billing & Reimbursement for Professionals	6.15.C. Payment in 15-Minute Increments	Subsection re-named: Payment in One-Hour Increments Subsection text was revised to read: Private duty nursing is prior authorized and paid in one-hour increments. When billing for services, the total number of hours billed (whether with S9123 and/or S9124) must not exceed the total number of hours authorized for that month. Since whole hours of care are authorized, only those hours of care that entail a full hour of care may be billed.
		Private Duty Nursing	1.7 Service Log	The example of the service log was revised. The following text was added after the service log example: PDN agencies should refer to the Billing & Reimbursement for Institutional Providers chapter for instructions on claim completion and requirements for the processing of claims. Medicaid-enrolled Registered Nurses (RN) or Licensed Practical Nurses (LPN) should refer to the Billing & Reimbursement for Professionals Chapter for instructions on claim completion and requirements for the processing of claims.

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		Private Duty Nursing	2.6 Change in Beneficiary's Condition/PDN as a Transitional Benefit (new subsection; following subsection re-numbered)	New subsection text: Medicaid policy requires that the integrated plan of care (POC) be updated as necessary based on the beneficiary's medical needs. Additionally, when a beneficiary's condition changes -- warranting a decrease in the number of approved hours or a discontinuation of services -- the provider must report the change to the appropriate authorizing agent (i.e., the Program Review Division, Children's Waiver, or Habilitation Supports Waiver). Changes such as weaning from a ventilator or tracheostomy decannulation can occur after months or years of services, or a beneficiary's condition may stabilize to the point of requiring fewer PDN hours or the discontinuation of hours altogether. It is important that the provider report all changes resulting in a decrease in the number of hours to the authorizing agent as soon as they occur, as well as properly updating the POC. MDCH will seek recovery of monies inappropriately paid to the provider if, during case review, the authorizing agent determines that a beneficiary required fewer PDN hours than was provided and MDCH was not notified of the change in condition. In some cases, the authorized PDN services may be considered a transitional benefit. In cases such as this, one of the primary reasons for providing services should be to assist the family or caregiver(s) to become independent in the care of the beneficiary. The provider, in collaboration with the family or caregiver(s), may decide that the authorized number of hours should be decreased gradually to accommodate increased independence on the part of the family, caregiver(s), and/or beneficiary. A detailed exit plan with instructions relating to the decrease in hours and possible discontinuation of care should be documented in the POC. The provider must notify the authorizing agent that hours are being decreased and/or when the care will be discontinued.
MSA 10-31	9/1/2010	Hearing Services	2.3 Cochlear Implants and Auditory Osseointegrated Devices (new subsection; following subsections re-numbered)	New subsection text: Cochlear implants are devices that replace the function of the cochlear structures or auditory nerve and provide electrical energy to auditory nerve fibers and other neural tissues via implanted electrode arrays. Auditory osseointegrated devices are devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer. One cochlear implant or auditory osseointegrated device may be covered per beneficiary. Replacements will be considered under prior authorization. Implantation in the contralateral (that is, a second implant) is not a benefit. Implantation is limited to one in either ear, but not both. As

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				such, repairs and accessories for these devices are limited to the approved device, not bilaterally. Only Food and Drug Administration (FDA) approved implant devices will be considered for prior authorization. Cochlear implant and auditory osseointegrated devices are billed by and reimbursed to the hospital through the usual billing and payment methodology.
		Hearing Services	2.3.A. Cochlear Implant Repair and/or Replacement of Parts	In the 1st paragraph, the following was added as the 1st sentence: Cochlear accessory replacements are not allowed during the warranty period and may only be dispensed by a cochlear implant manufacturer.
		Hearing Services	2.3.B. Cochlear Implant Parts Replacement Maximums	Subsection name revised to read: Cochlear Implant Replacement Part Maximums Items were added to the list of replacement parts.
		Hearing Services	2.5 Replacement of Auditory Osseointegrated Devices (new subsection)	New subsection text: Replacement of external processors for surgically placed auditory osseointegrated devices requires prior authorization and will not be covered more frequently than once every five years. Replacements are not covered during the warranty period. Processor repairs require prior authorization.

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		Hearing Services	2.6 Reimbursement for Procedure Codes Identified with Not Otherwise Covered (NOC) or $0.01 Screen (new subsection)	New subsection text: MDCH reserves the right to set a dollar limit on the maximum allowable amount paid for a NOC or $0.01 screen procedure code for a specific range of products.

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Supplemental Bulletin List

October - December 2010

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. Providers using a CD version of the Medicaid Provider Manual should retain all quarterly manual update bulletins, with their attachments, in addition to bulletins issued since the version date of the CD.

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
12/01/10	MSA 10-62	Transitional Medicaid Plus Program (TMA-Plus) Premiums	All Providers and Bridges Manual Holders	
12/01/10	MSA 10-61	Outpatient Prospective Payment System and Ambulatory Surgical Center Reduction Factor	Hospitals, Ambulatory Surgical Centers, Hospital-Owned Ambulance, Comprehensive Outpatient Rehabilitation Facilities, Rehab Agencies, Freestanding Dialysis Centers, Medicaid Health Plans, County Health Plans	
12/01/10	MSA 10-60	Preadmission Diagnostic Services – Three Day (or one day) Payment Window - Outpatient Services Treated as Inpatient Services	Hospitals	
12/01/10	MSA 10-59	Telephone Prior Authorization for Care in Medicaid-Enrolled Ventilator Dependent Care Units (VDCU)	VDCUs	

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DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
12/01/10	MSA 10-58	Billing Long Term Care Insurance, and Reporting National Uniform Billing Committee (NUBC) Value Codes 22 and 66	Nursing Facilities, County Medical Care Facilities, Hospital Long-Term Care Units, Hospital Swing Beds, Ventilator Dependent Care Units, Hospice, and Home Health Agencies	
12/01/10	MSA 10-57	Graduate Medical Education (GME) Payment Timing and Increase in Allocations to Indigent Care Agreement (ICA), Small Hospital, and Outpatient Uncompensated Care Disproportionate Share Hospital (DSH) Pools	Hospitals	
12/01/10	MSA 10-56	Non-Emergency Medical Transportation (NEMT) Program in Wayne, Oakland, and Macomb Counties	Chiropractors, Dentists, Hearing Aid Dealers, Hearing and Speech Centers, Home Health, Hospice, Hospitals, Laboratories, Medicaid Health Plans, Medical Suppliers, Mental Health and Substance Abuse, Pharmacy, Practitioners, Rural Health Clinics, Tribal Health Centers, and Vision providers in affected counties	
12/01/10	MSA 10-54	Upcoming Michigan Department of Community Health (MDCH) Implementation of the Health Insurance Portability and Accountability Act (HIPAA) 5010 and ICD-10	All Providers	

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12/01/10	MSA 10-53	New Telephone Prior Authorization Process for Selected Durable Medical Equipment and Medical Supplies	Hospitals, Physicians, Medical Suppliers, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers	
12/01/10	MSA 10-52	Requests for Mobility Device Repairs, Use of Modifiers RA & RB, and Replacement of Durable Medical Equipment (DME) Parts/Components	Medical Suppliers and Physicians	
10/01/10	MSA 10-46	Institutional Crossover Claims	Hospitals, Nursing Facilities, County Medical Care Facilities, Hospital Long-Term Care Units, Hospital Swing Beds, Outpatient County Medical Care Facilities, Ventilator Dependent Care Units, Hospice, Private Duty Nursing, Home Health Agencies, Federally Qualified Heath Centers, and Rural Health Clinics	
6/15/10	MSA 10-23	Ambulatory Surgical Centers - Recognition and Reimbursement	Ambulatory Surgical Centers, Medicaid Health Plans, Hospitals	