MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 11-07

Distribution: All Providers

Issued: March 1, 2011

Subject: Updates to the Medicaid Provider Manual; Electronic Healthcare Transactions; Ambulatory Surgical Centers; Community Health Automated Medicaid Processing System (CHAMPS) Provider Helpline and E-Mail Address; Code Updates

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 April 2011 update of the online version of the Medicaid Provider Manual. Attachments to this bulletin describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change. Attachment II describes changes made to incorporate information from recently issued Medicaid Bulletins. These changes appear in blue 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. If both technical and bulletin incorporation changes apply to the section/subsection, color coding will be limited to reflect a bulletin-related change.

Electronic Healthcare Transactions

Effective January 1, 2012, providers must submit electronic healthcare transactions using the X12 version 5010. Providers who do not convert to version 5010 by the compliance date will have their claims and other transactions rejected. Reimbursement delays and resubmission costs could occur. Providers should be working with their information technology (IT) staff, vendor, or clearinghouse to confirm they can support 5010 requirements and ICD-10 code sets.

MDCH is planning to send a survey to our Trading Partners to assess their 5010 implementation readiness. In addition to the survey, MDCH created a new website at www.michigan.gov/5010ICD10 with information regarding the 5010 and ICD-10 project, and links to other resources. For additional questions, e-mail MDCH-5010@michigan.gov.

Ambulatory Surgical Centers

Effective April 1, 2011, MDCH incorporated policy bulletins MSA 10-23 and MSA 10-63 into the MDCH Medicaid Provider Manual, creating a separate Ambulatory Surgical Centers (ASC) chapter. In addition, clarification is provided in relation to the Centers for Medicare & Medicaid Services (CMS) assignment of a two-digit status indicator to each Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. This corrects earlier single-digit status indicator language that was provided.

The MDCH specific Status Indicator key was revised to accurately reflect the services covered differently than Medicare with the following alpha/numeric status indicators.

AA1 = MDCH Covered Medicare Non-Covered
AA2 = MDCH Covered Adult Vaccines
AA3 = Vaccines for Children (VFC)
AA4 = State Plan Reimbursement
RR1 = MDCH Non-Covered

The ASC Wrap Around Code List was revised accordingly to reflect the updates (retroactive to January 1, 2011).

CHAMPS Provider Helpline and E-Mail Address

The CHAMPS Provider Helpline number (1-888-643-2408) and the CHAMPS e-mail address (CHAMPS@michigan.gov) will be disabled effective March 30, 2011. Providers should direct all CHAMPS and Medicaid-related questions to the Medicaid Provider Inquiry Helpline at 1-800-292-2550 or to the Provider Support e-mail address at providersupport@michigan.gov.

In addition, the CHAMPS website located at www.michigan.gov/medicaidproviders >> CHAMPS is updated frequently. Providers should reference this website for CHAMPS information.

Immunization Updates

Reference: Code 90715

Consistent with the Advisory Committee on Immunization Practices (ACIP) guidelines, MDCH is expanding the lower age limit for the Tetanus, diphtheria toxoids, and acellular pertussis (Tdap) to individuals as young as 7 years in the VFC program. This lower age limit is effective for dates of service on and after January 1, 2011.

Retroactive Coverage of Existing Codes

The following Prior Authorization (PA) change requirements are effective January 1, 2011 for: 1) Physicians, Practitioners and Medical Clinics; 2) MDCH Outpatient Prospective Payment System (OPPS)/Ambulatory Payment Classification (APC) (where applicable); and 3) MDCH ASCs (where applicable).

MDCH aligns, as closely as possible, with Medicare and is adding the ICD-9-CM diagnosis code editing of existing Medicaid covered services of the affected, and the contralateral unaffected, breast if billed appropriately and performed in the appropriate place of service.

Effective for dates of service on and after January 1, 2011, MDCH will bypass the PA requirement of breast reconstruction procedures for breast cancer following a medically necessary mastectomy when billed with the appropriate ICD-9-CM diagnosis code. The diagnosis code editing to bypass PA applies to the following Medicaid-covered services/CPT codes:

19316	19340	19355	19364	19368	19371
19318	19342	19357	19366	19369	19380
19324	19350	19361	19367	19370	19396
19325					

- Effective for dates of service on and after January 1, 2011, PA is required for existing coverage of removal of a breast implant (CPT 19328 and 19330) when considered medically necessary. MDCH will bypass the PA requirement only when billed with the appropriate ICD-9-CM diagnosis.

Effective for dates of service on and after January 1, 2011, MDCH will bypass the PA requirement for existing coverage of removal of a breast implant (CPT 19370, 19371 and 19380) when billed with the appropriate ICD-9-CM diagnosis codes.

April 1, 2011 Healthcare Common Procedure Coding System (HCPCS) Code Update

The following code will be covered for dates of service on and after April 1, 2011, when billed by Physicians, Practitioners, and Medical Clinics:

Q2040 - Injection, Incobotulinumtoxin A, 1 unit

New Coverage of Existing Codes

The following codes will be covered effective April 1, 2011, when billed by Physicians, Practitioners, Medical Clinics, OPPS/APC, and ASC:

0073T 0099T

Wrap Around Code List Revisions

The MDCH OPPS/APC Wrap Around Code List has been revised to reflect R1 non-coverage of existing codes retroactive to January 1, 2011, as follows:

0019T 0071T 0072T

The MDCH OPPS/APC and ASC Wrap Around Code Lists have been revised to reflect R1 non-coverage of existing codes retroactive to January 1, 2011, as follows:

0100T 0101T 0102T 0123T 0124T

Manual Maintenance

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

Questions

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

Approved

Stephen Fitton, Director
Medical Services Administration

Michigan Department of Community Health

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April 2011 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	14.7 Clinical Records	In the 5th paragraph, the 2nd sentence was revised to read: ... any clinical information required to comply with 42 CFR 483.75(l) and the plan ...	Correction
Coordination of Benefits	1.2 Verification of Other Insurance	The 3rd paragraph was revised to read: ..., the beneficiary should be instructed to notify his local Department of Human Services (DHS) office of the change. If the provider elects to initiate a change to the beneficiary eligibility response, the Request to Add, Terminate, or Change Other Insurance (form DCH-0078) should be completed. (Refer to the Forms Appendix for a copy of the form and additional instructions.)	Language added to address use of optional form.
Billing & Reimbursement for Institutional Providers	9.1 Direct Billing to MDCH	Information for "Billable Units" was revised to read: PDN services are authorized, billed, and paid in hourly increments. The total number of units (hours) reported on the claim must not exceed the total units (hours) that were 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.	result of Bulletin MSA 10-35
Billing & Reimbursement for Professionals	6.16.A. Direct Billing to MDCH	Information for "Billable Units" was revised to read: PDN services are authorized, billed, and paid in hourly increments. The total number of units (hours) reported on the claim must not exceed the total units (hours) that were 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.	result of Bulletin MSA 10-35
Children's Special Health Care Services	2.2.B. Providers Not Requiring Authorization	The following was added at the end of the paragraph: The NPI of the CSHCS authorized ordering or prescribing provider must be entered in the appropriate field on the claim.	Clarification
Children's Special Health Care Services	Section 8 - Coverage Period	In the 3rd paragraph, the 1st sentence was revised to read ... based on age and family income.	Clarification

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

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CHAPTER	SECTION	CHANGE	COMMENT
Hospice	6.3.A. Rate Methodology	The paragraph was revised to read: MDCH uses the Medicaid hospice payment base rates established and provided by CMS and applies the appropriate local wage adjustors provided by CMS for the four categories of hospice care in each Core Based Statistical Area (CBSA). Medicaid publishes and implements rate updates each fiscal year or when directed by CMS. (Refer to the MDCH Hospice Reimbursement Rates on the MDCH website.)	Clarification
Hospital	6.9.A. Medicaid Ventilator-Dependent Care	In the 1st paragraph, the last sentence was removed. "(Refer to the Directory Appendix for contact information.)"	Obsolete information
Hospital Reimbursement Appendix	7.1.A. Indigent Volume Report and Disproportionate Share Hospital Eligibility Form	In the 5th paragraph, in the example form, the following information was added to item #1 and item #2: First Physician Name and NPI: _____ Second Physician Name and NPI: _____	Update
Mental Health/ Substance Abuse	2.3 Location of Service	The 5th paragraph was revised to read: Medicaid does not cover services delivered in Institutions of Mental Disease (IMD) for individuals between ages 22 and 64, as specified in §1905(a)(B) of the Social Security Act. Medicaid does not cover services provided to children with serious emotional disturbance in Child Caring Institutions (CCI) unless it is for the purpose of transitioning a child out of an institutional setting (CCI). The following mental health services initiated by the PIHP (the case needs to be open to the CMHSP/PIHP) may be provided within the designated timeframes: • Assessment of a child's needs for the purpose of determining the community based services necessary to transition the child out of a CCI. This should occur up to 60 days prior to the anticipated discharge from a CCI. • Wraparound planning or case management. This should occur up to 60 days prior to discharge from a CCI.	Clarification -- based on questions raised from the field

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		Medicaid does cover services provided to children with developmental disabilities in a CCI that exclusively serves children with developmental disabilities, and has an enforced policy of prohibiting staff use of seclusion and restraint. Medicaid does not cover services provided to persons/children involuntarily residing in non-medical public facilities (such as jails, prisons or juvenile detention facilities).	
Mental Health/ Substance Abuse	6.2.A. Child Crisis Residential Services	The paragraph was revised to read: Child Crisis Residential Services may not be provided to children with serious emotional disturbances in a Child Caring Institution (CCI). The program must include on-site nursing services (RN or LPN under appropriate supervision). • For settings of six beds or fewer: on-site nursing must be provided at least one hour per day, per resident, seven days per week, with 24-hour availability on-call. • For 7-16 beds: on-site nursing must be provided eight hours per day, seven days per week, with 24-hour availability on-call.	Clarifies that on-site nursing requirements for Child Crisis Residential Services are the same as Adult Crisis Residential Services.
Mental Health/ Substance Abuse	15.2.B. Trained Supports Coordinator Assistant Qualifications	The following bullet point was added: • At least 18 years of age.	For consistency with other staff qualification descriptions.
Mental Health/ Substance Abuse	15.2.C. Aide Qualifications	The 5th bullet point was revised to read: • Able to perform basic first aid procedures, as evidenced by completion of a first aid training course, self-test, or other method determined by the PIHP to demonstrate competence in basic first aid procedures.	Clarification
Mental Health/ Substance Abuse	15.2.D. Services and Supports Broker Qualifications	The following bullet point was added: • At least 18 years of age.	For consistency with other staff qualification descriptions.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	5.2.B. Provider Appeals	The 3rd sentence was revised to read: Information regarding the MDCH appeal process is available in the General Information for Providers Chapter and on the MDCH website.	Clarification
Nursing Facility Coverages	10.3 Ancillary Services	In the 5th paragraph, the 1st sentence was revised to read: Nursing facilities may not bill Medicaid for ancillary services except for therapies, oxygen, and the Medicare coinsurance or deductible for ancillary services.	Update
Nursing Facility Coverages	12.2 Ventilator-Dependent Care Units	The following was added at the end of the 2nd sentence: ..., and for which there is an enhanced Medicaid reimbursement.	Clarification
Nursing Facility Certification, Survey & Enforcement Appendix	5.9 Minimum Data Set - Resident Assessment Instrument	In the 1st paragraph, the 1st sentence was revised to read: A nursing facility is required to submit resident assessments to the QIES ASAP system using the Medicare Data Communication Network (MDCN). Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B).	Update
Pharmacy	11.2 Acute and Maintenance Supplies	In the 2nd bullet point, references to "100-day supply" were revised to read "102-day supply".	Update
Private Duty Nursing	1.6 Benefit Limitations	In the 1st paragraph, the 4th sentence was revised to read: The calculation of the number of hours authorized per month includes eight hours or more of care that will be provided by the caregiver ...	Clarification
Program of All-Inclusive Care for the Elderly	Section 2 - Services	In the 2nd paragraph, the following bullet point was added: • End-of-Life care	Update

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CHAPTER	SECTION	CHANGE	COMMENT
Program of All-Inclusive Care for the Elderly	3.1 Eligibility Requirements	The 2nd bullet point was revised to read: • Meet applicable Medicaid financial eligibility requirements. (Eligibility determinations will be made by the Michigan Department of Human Services.)	Update
Program of All-Inclusive Care for the Elderly	3.11.A. Financial Eligibility	The paragraph was revised to read: A determination that an applicant is not financially eligible for Medicaid is an adverse action. Applicants may appeal to the Michigan Department of Human Services (MDHS). (Refer to the Directory Appendix for contact information.)	Update
Program of All Inclusive Care for the Elderly	3.12 Provider Appeals	The last sentence was revised to read: If the PACE organization disagrees with this determination, an appeal may be filed with MDCH. Information regarding the MDCH appeal process is available in the General Information for Providers Chapter and on the MDCH website. (Refer to the Directory Appendix for website information.)	Clarification
Acronym Appendix		Addition of: MDCN - Medicare Data Communication Network	Update
Directory Appendix	PHARMACY RESOURCES MAC Pricing Information	Fax number updated to read: 888-656-1951	Update
Directory Appendix	PHARMACY RESOURCES Pharmacy Audit	Removed topic/information line for "Pharmacy Audit."	Obsolete information
Directory Appendix	PHARMACY RESOURCES Drug Rebate Specialist	Fax number updated to read: 517-241-7816	Update

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Forms Appendix		Revisions of: MSA-0003-EZ; Consent Forms Approval Area DCH-1401; Electronic Signature Agreement DCH-1164; Guarantee of Payment Letter for Pregnancy Related Services MSA-0002-EZ; Institutional Claim Documentation Review Area Fax Cover MSA-0001-EZ; Professional/Dental Claim Documentation Review Area Fax Cover	reflects updated letterhead
		Revision of DCH-1074; Hospice Membership Notice: • Under Section II, the introductory question was revised to read: "Is beneficiary currently in a Nursing Facility, Hospice-Owned Nursing Facility, or Ventilator-Dependent Care Unit?" • On page 2 under "Certification", the 1st sentence was revised to read: "... or the person indicated in item number 20."	General correction/maintenance
		Addition of: DCH-0078; Request to Add, Terminate or Change Other Insurance	Update

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MSA 11-07	3/1/2011	throughout Manual		Technical Changes and Bulletin Incorporation completed as noted.
		Directory Appendix	Billing Resources	Information line added: Contact/Topic: Electronic Healthcare Transactions E-Mail Address: MDCH-5010@michigan.gov Web Address: www.michigan.gov/5010ICD10 Information Available/Purpose: Information regarding X12 version 5010 transactions and ICD-10 code sets
			Provider Assistance; Eligibility Verification	Revisions to CHAMPS contact information revised as follows: Phone: CHAMPS Helpline (1-888-643-2408) changed to Medicaid Provider Inquiry Helpline (1-800-292-2550) E-Mail: changed from CHAMPS@michigan.gov to providersupport@michigan.gov
MSA 11-05	2/24/2011	School Based Services Random Moment Time Study	3.2 Random Moment Time Study Form Completion	In the 3rd paragraph, text after the 2nd sentence was revised to read: There are four separate staff pools sampled for the RMTS each quarter: 1) the AOP only staff pool, 2) the AOP and FFS/Direct Medical Services staff pool, 3) the Personal Care Services staff pool, and 4) the Targeted Case Management Services staff pool. All staff pools have 800 moments randomly selected for the summer quarter (July-September). For the remaining three quarters, the Direct Medical Services and the Targeted Case Management Services staff pools have 3,000 moments randomly selected per quarter, and the Personal Care Services staff pool has 3,200 moments randomly selected per quarter. The person's name that is associated with each moment is placed on a time study form. The Contractor distributes the control lists of their selected staff and the time study forms to the ISDs prior to the beginning of the reporting period. The Contractor is also responsible for the collection of all time study forms for the ISDs.
MSA 11-01	1/1/2011	Hospice	5.8 Concurrent Hospice and Curative Care for Children	New subsection text reads: Children under 21 years of age may receive hospice care concurrently with curative treatment of the child's terminal illness. This allows the beneficiary or beneficiary's representative to elect the hospice

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			(New subsection; following subsections re-numbered)	benefit without forgoing any curative service to which the child is entitled under Medicaid for treatment of the terminal condition. The need for hospice care must by certified by a physician and the hospice medical director. Medicaid will reimburse for the curative care separately from the hospice services. Medicaid will not reimburse for these types of treatments when they are used palliatively. As such, they are the responsibility of the hospice and must be included in the per diem cost.
MSA 10-64	12/21/2010	General Information for Providers	Section 18 - Electronic Health Record (EHR) Incentive Program (new section)	New section text reads: The American Recovery and Reinvestment Act of 2009 (Recovery Act) provides the opportunity for state Medicaid programs to improve the nation's healthcare through health information technology (HIT) by authorizing incentives for certain eligible professionals (EP), eligible hospitals (EH) and Critical Access Hospitals (CAH) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use of EHR technology for up to five remaining participation years. The HIT provisions of the Recovery Act are primarily found in Title XIII, Division A, Health Information Technology, and in Title IV, Division B, Medicare and Medicaid Health Information Technology. These titles, taken together, are referred to as the Health Information Technology for Economic and Clinical Health (HITECH) Act. The Michigan Medicaid EHR Incentive Program is consistent with the Centers for Medicare & Medicaid Services (CMS) Final Rule 0033 published in the Federal Register (July 28, 2010). The Recovery Act established 100 percent Federal Financial Participation (FFP) to provide incentive payments to eligible Medicaid providers to purchase, implement, and operate, including support services and staff training, and certified EHR technology. Eligible professionals and hospitals must meet patient volume thresholds to be eligible for the program. Incentive payments after the initial adoption, implementation, and upgrading of EHR technology require the provider to demonstrate "meaningful use" of the EHR technology. This is done through a means determined by the State and approved by CMS. The State may also require providers to report clinical quality measures as a part of "meaningful use". As required by CMS, the EHR technology must be compatible with State and Federal administrative management systems and certified with the Certification of Health IT Program under the Office of the National Coordinator for Health Information Technology (ONC).

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				To participate in the Medicaid EHR incentive program, providers must: • register with the National Level Repository (NLR) at the federal level. To register with the NLR, providers must have a National Provider Identifier (NPI). • register as a provider in the Community Health Automated Medicaid Processing System (CHAMPS). Those who are providing services through managed care entities must be individually registered as a Medicaid provider in CHAMPS to verify the provider is in good-standing and is eligible to receive an EHR incentive. Revisions to provider information in the EHR section of CHAMPS will need to be updated by the provider through the NLR. • have an active user account in the National Plan and Provider Enumeration System (NPPES). • Hospitals must be enrolled in the CMS Provider Enrollment, Chain and Ownership System (PECOS). CMS will use the NLR, NPPES and PECOS to register the provider for the program and verify their registration prior to notifying Michigan of eligibility status. Additional information can be found on websites specific to the Incentive Program. (Refer to the Directory Appendix for website information.)
		Acronym Appendix		addition of: CAH - Critical Access Hospitals EH - eligible hospitals (NOTE: Term applies to EHR Incentive Program only.) EHR - Electronic Health Record EP - eligible professionals (NOTE: Term applies to EHR Incentive Program only.) FFP - Federal Financial Participation HIT - Health Information Technology HITECH - Health Information Technology for Economic and Clinical Health Act NLR - National Level Repository

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				NPI - National Provider Identifier NPPES - National Plan and Provider Enumeration System ONC - Office of the National Coordinator for Health Information Technology PECOS - Provider Enrollment, Chain and Ownership System
		Directory Appendix	Miscellaneous Contact Information	Information line added: Contact/Topic: Electronic Health Record (EHR) Incentive Program Web Address: www.michiganhealthit.org www.cms.gov/EHRIncentivePrograms Information Available/Purpose: Information regarding the EHR Incentive Program
MSA 10-63 & MSA 10-23	12/2/2010 6/15/2010	Ambulatory Surgical Centers (new chapter)		New chapter added to the Medicaid Provider Manual to address subject matter for Ambulatory Surgical Centers.
		Acronym Appendix		Addition of: ASC - Ambulatory Surgical Center
		Directory Appendix	Billing Resources	Under "Contact/Topic" (MDCH Procedure Code Databases/Fee Screens ...), ASC Wrap Around Code List was added to "Information Available/Purpose."
MSA 10-60	12/1/2010	Billing & Reimbursement for Institutional Providers	6.16 Preadmission Diagnostic Services (new subsection; following subsections re-numbered)	New subsection text reads: MDCH policy/billing guidelines align with billing guidance referenced in the Medicare Claims Processing Manual and the applicable section (i.e., date specific) for "Outpatient Services Treated as Inpatient Services". MDCH does not differentiate any specialty hospitals or facilities referenced in the CMS policy (i.e., critical access hospital [CAH], cancer, rehab, etc.). (NOTE: This policy does not apply to ambulance

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				providers and freestanding dialysis centers.) MDCH will use a hospital's tax identification number to align with the CMS definition of "any hospital entity that is wholly owned or wholly operated by" the hospital. Otherwise, MDCH will align as closely as possible with Medicare policy and guidelines for all beneficiaries.
		Hospital	3.25 Preadmission Diagnostic Services (new subsection; following subsections re-numbered)	New subsection text reads: MDCH follows Medicare policy for all preadmission diagnostic services and other preadmission services (outpatient services treated as inpatient) with a few exceptions in compliance with the law. All non-diagnostic services rendered in the three-day window prior to the inpatient hospital admission may not be billed separately and must be bundled into the inpatient stay, unless the hospital can document they are unrelated services. MDCH aligns with Medicare billing guidelines.
MSA 10-59	12/1/2010	Nursing Facility Coverages	12.2.B. Authorization for VDCU Placement	Paragraphs 1 through 5 were revised to read: To begin the prior authorization process once a VDCU has agreed to accept the beneficiary, the VDCU must contact (by telephone) the MDCH Medicaid Prior Authorization Contractor for authorization. The Medicaid Prior Authorization Contractor will consider the request for ventilator-dependent unit care based on current Medicaid policy. The request will be approved or denied immediately during the telephone call. (Refer to the Directory Appendix for contact information.) NOTE: If the PA request is approved, the Medicaid Prior Authorization Contractor will: • request the VDCU's National Provider Identifier (NPI) for inclusion in the prior authorization record; and • provide the VDCU with a prior authorization number for billing purposes. The 6th paragraph was revised to read: ... and deaths of these complex care residents to the Medicaid Prior Authorization Contractor.
		Directory Appendix	PRIOR AUTHORIZATION Prior Authorization -	Contact/Topic: added "(MDCH Medicaid Prior Authorization Contractor)" Telephone number changed to: 800-727-7223

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			Ventilator-Dependent Care Units (MDCH Medicaid Prior Authorization Contractor)	Fax number was deleted. Mailing Address changed to: Michigan Peer Review Organization 22670 Haggerty Rd., Ste. 100 Farmington Hills, MI 48335-2611
		Forms Appendix		Removal of obsolete forms: MSA-1634; Medicaid Ventilator Dependent Care Assessment MSA-1635; Medicaid Ventilator Dependent Care Authorization
MSA 10-57	12/1/2010	Hospital Reimbursement Appendix	7.2.B. $5M Small Hospital DSH Pool	The subsection title was revised to read: Small Hospital DSH Pool In the 1st paragraph, the 1st sentence was revised to read: A total of $7.5 million in funding ... In the 1st and 2nd paragraphs, references to the DSH pool were revised to read "Small Hospital DSH Pool."
			7.3.B. Indigent Care Agreements Pool	In the 1st paragraph, the 5th sentence was revised to read: This pool will be $172,343,362 in fiscal year 2006, $147,687,951 in fiscal year 2007, $122,707,686 in fiscal year 2008, $110,937,485 in fiscal year 2009, $125,001,655 in fiscal year 2010, and $88,518,500 each subsequent fiscal year.
			7.3.D. Outpatient Uncompensated Care DSH Pool	In the 1st paragraph, the 2nd sentence was revised to read: The pool amount will be $38,300,000 in fiscal year 2007, $63,200,000 in fiscal year 2008, $60,000,000 in fiscal year 2009, $87,000,000 in fiscal year 2010 and $60,000,000 each subsequent fiscal year.

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<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td></td><td></td><td></td><td></td><td>In the 3rd paragraph, the table was revised to read:
<table>
<tr><th>Component</th><th>Fiscal Year 2007</th><th>Fiscal Year 2008</th><th>Fiscal Year 2009</th><th>Fiscal Year 2010</th><th>Subsequent Fiscal Years</th></tr>
<tr><td>Small and Rural Components</td><td>$18,900,000</td><td>$31,100,000</td><td>$30,000,000</td><td>$43,500,000</td><td>$30,000,000</td></tr>
<tr><td>Large-Urban Components</td><td>$19,400,000</td><td>$32,100,000</td><td>$30,000,000</td><td>$43,500,000</td><td>$30,000,000</td></tr>
<tr><td>TOTALS</td><td>$38,300,000</td><td>$63,200,000</td><td>$60,000,000</td><td>$87,000,000</td><td>$60,000,000</td></tr>
</table></td></tr>
<tr><td>MSA 10-53</td><td>12/1/2010</td><td>Directory Appendix</td><td>Prior Authorization (Authorization of Services)</td><td>Information line added:
Contact/Topic: Prior Authorization - DME (MDCH Medicaid Prior Authorization Contractor)
Telephone number: 800-727-7223
Mailing Address: Michigan Peer Review Organization
22670 Haggerty Rd., Ste. 100
Farmington Hills, MI 48335-2611
Information Available/Purpose: Prior authorization of specific DME equipment and medical supplies (applies to applicable procedure codes requiring prior authorization; noted on Medical Supplier/DME/Prosthetics and Orthotics Database on MDCH website)</td></tr>
<tr><td>MSA 10-52</td><td>12/1/2010</td><td>Medical Supplier</td><td>1.8.C. Repairs and Replacement Parts</td><td>The following text was inserted after the 4th paragraph:
Modifiers to be used when requesting replacements/repairs are as follows:
<table>
<tr><th>Modifier</th><th>Description</th></tr>
<tr><td>RA</td><td>Replacement of a DME, orthotic or prosthetic item</td></tr>
<tr><td>RB</td><td>Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair</td></tr>
</table></td></tr>
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*Bulletin inclusion updates are color-coded to the quarter in which the update was made (April 1 = Blue; July 1 = Pink; October 1 = Green)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				The following text was inserted after the 7th paragraph: The RA modifier should be reported with the appropriate HCPCS code of the DME to be replaced and should be reported when replacing a DME item with an identical or nearly identical item.
			2.47.C. Prior Authorization for Purchase, Rentals, Repairs, and/or Replacement of Mobility Devices	Under "Rentals, Repairs and Replacement", the following was added as a 4th paragraph: Medicaid will not authorize coverage of replacement of any DME item or accessory that is requested solely because new technology is available. Replacement or modifications must be medically necessary and required as a result of a change in the medical condition that makes the covered service unusable or contraindicated.
MSA 10-46	10/1/2010	Coordination of Benefits	Section 4 - Crossover Claims	The following text was added at the end of the 1st paragraph: Refer to the specific claim type chapters within this manual for further billing instructions.
			4.1 Acceptable Crossover Claims	In the 1st paragraph, the 1st sentence was revised to read: MDCH accepts Medicare Part A institutional claims (inpatient and outpatient) and Medicare Part B professional claims ...
			4.2 Claims Excluded From Crossover Process	The following text was added as a 3rd paragraph: Additional information regarding crossover billing and exclusions can be found on the MDCH website. (Refer to the Directory Appendix for website information.)
		Directory Appendix	Billing Resources	Information line added: Contact/Topic: Medicare Crossover Claims Web Address: www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Medicare Crossover Information Available/Purpose: Information regarding Medicare Crossover billing and exclusions

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Michigan Department of Community Health

Supplemental Bulletin List

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

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

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	COMMENTS
03/01/2011	MSA 11-12	Claims for Immunizations	Local health Departments (LHD), Medicaid Health Plans (MHP)	
03/01/2011	MSA 11-11	Concurrent Hospice and Curative Care for Children	Hospice, Medicaid Health Plans, MIChild Health Plans, MIChild Manual Holders, Local Health Departments, MIChild Administrative Contractor (MAXIMUS), Department of Human Services Central Office, Tribal Health Clinics, Federally Qualified Health Centers	
03/01/2011	MSA 11-10	Countable Assets for Medicaid	Bridges Eligibility Manual holders	
03/01/2011	MSA 11-09	Clarification to Bulletin MSA 10-53	Hospitals, Physicians, Medical Suppliers, Federally Qualified Health Care Centers, Rural Health Clinics, Tribal Health Centers	

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Supplemental Bulletin List

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	COMMENTS
03/01/2011	MSA 11-08	Rebasing Diagnosis Related Group (DRG) Rates; DRG Grouper Update; Per Diem Rates Update; Present on Admission Indicators and Non-Payment for Hospital Acquired Conditions	Hospitals, Medicaid Health Plans (MHP)	
03/01/2011	MSA 11-06	Medicaid National Correct Coding Initiative (NCCI)	All Providers	
02/16/2011	MSA 11-04	Electronic Health Record Incentive Program for Hospitals	Hospitals	
01/31/2011	MSA 11-03	Corrections to Bulletin MSA 10-65	All Providers	Information regarding fee screens and coverage parameters is located in the appropriate database posted on the Michigan Department of Community Health (MDCH) website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.
01/01/2011	MSA 11-02	Additional Codes Payable to Family Planning Clinics	Family Planning Clinics	Code information is available on the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Family Planning