MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 11-18

Distribution: All Providers

Issued: June 1, 2011

Subject: Updates to the Medicaid Provider Manual; Additional Code for Plan First!; 5010/ICD-10 Update

Effective: As Indicated

Programs Affected: Medicaid, Adult Benefits Waiver, Children's Special Health Care Services (CSHCS), 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 July 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 pink in the online version of the manual. The July 2011 version of the Manual will be available on the MDCH website on July 1, 2011.

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.

Additional Code for Plan First!

Effective for dates of service on and after April 1, 2011, providers can bill the following Current Procedural Terminology (CPT) code when completed as a family planning follow-up service.

74740 Hysterosalpingography, radiological supervision and interpretation

5010/ICD-10 Update

MDCH will implement the Health Insurance Affordability and Accountability Act of 1996 (HIPAA) version 5010 for submitting electronic healthcare transactions on January 1, 2012. An informational webpage has been added to the MDCH website at www.michigan.gov/5010icd10 to assist providers with the planned implementation of the HIPAA 5010 version. The website provides information to assist in the transition process and includes 5010 Companion Guides and instructions for 5010 testing. Information for the planned implementation of ICD-10 on October 1, 2013, will now be added.

Providers are encouraged to check the site often as information will be updated and added regularly.

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

Medicaid Provider Manual
July 2011 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Medicaid Provider Manual Overview	1.1 Organization	The following was added to the table under "Provider/Service Specific Chapters": Ambulatory Surgical Centers Information regarding billing, coverage, and reimbursement policies related to Ambulatory Surgical Centers.	Update
Medicaid Provider Manual Overview	3.1 Quarterly Updates	The following was added as a 3rd paragraph: A compact disc (CD) version of the Medicaid Provider Manual is available to enrolled Medicaid providers upon request. (Refer to the Directory Appendix for contact information.)	Update
Medicaid Provider Manual Overview	3.2 Yearly Updates	Subsection removed; following subsection re-numbered.	Obsolete information
General Information for Providers	Section 2 - Provider Enrollment	In the 5th paragraph, the 1st sentence was revised to read: Pharmacies must have a completed Pharmacy Provider Enrollment ...	Revised to accommodate electronic submissions
General Information for Providers	Section 7 - Sanctioned, Nonenrolled, and Borderland Providers	The section name was revised to read: Sanctioned, Nonenrolled, Borderland, and Out of State/Beyond Borderland Providers	For consistency in Manual language
Billing & Reimbursement for Institutional Providers	1.1 Claims Processing System	The following sentence was moved from the end of the 2nd paragraph to the end of the 3rd paragraph: Electronic claims submitted by Wednesday may be processed as early as the next weekly cycle.	Relocated for placement/flow of information

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	6.12 Injections	The 4th paragraph was revised to read: The NDC information must be reported on all Medicare crossover claims.	Replaced "may" with "must" to align with Practitioner Chapter.
Billing & Reimbursement for Professionals	1.1 Claims Processing System	The following sentence was moved from the end of the 2nd paragraph to the end of the 3rd paragraph: Electronic claims submitted by Wednesday may be processed as early as the next weekly cycle.	Relocated for placement/flow of information
Billing & Reimbursement for Professionals	6.4 Ancillary Medical Services	Information for "Component Billing" was revised to read: For diagnostic tests with global, professional and technical components, practitioners can bill the global service only in the non-facility setting. The professional component may be billed in any setting. Technical component procedures are institutional charges and are not to be billed separately by practitioners when performed in facility settings.	Revised for consistency of information in the Billing & Reimbursement for Professionals and the Practitioner chapters.
Billing & Reimbursement for Professionals	6.17 Radiology Services	Information for "Component Billing" was revised to read: For radiology services with global, professional and technical components, practitioners can bill the global service only in the non-facility setting. The professional component may be billed in any setting. Technical component procedures are institutional charges and are not to be billed separately by practitioners when performed in facility settings.	Revised for consistency of information in the Billing & Reimbursement for Professionals and the Practitioner chapters.
Billing & Reimbursement for Professionals	7.5 Component Billing	"Special Instructions" for the TC modifier were revised to read: Technical component procedures are institutional charges and are not to be billed separately by practitioners when performed in facility settings.	Revised for consistency of information in the Billing & Reimbursement for Professionals and the Practitioner chapters.
Ambulatory Surgical Centers	2.1 ASC Payment – Status Indicators	In the table in the 2nd paragraph, the "Description" for AA2 was revised to read: MDCH Covered	Clarification

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Ambulatory Surgical Centers	Section 3 – ASC Reimbursement	The following was added at the end of the paragraph: Reimbursement for Ambulatory Surgical Center services will be monitored and adjustments will be made to the MDCH reduction factor as necessary to ensure spending limits fall within the MDCH appropriation. A wage index of 1.0 is applied for all Ambulatory Surgical Centers.	Added for clarification
Ambulatory Surgical Centers	3.6. Application of Statewide Outpatient Cost-to-Charge Ratio	The following was added at the end of the paragraph: Updates of hospital cost-to-charge ratios are done in conjunction with updates to the inpatient operating ratios.	Added for clarification
Hearing Aid Dealers	2.6.C. Prior Authorization Requirements	The 1st paragraph was revised to read: ... billed within the past 365 days is equal to or less than the maximum fee as identified on the Hearing Aid Dealers database. In the 2nd paragraph, the 1st and 2nd bullet points were revised to read: • ... payment amounts over the maximum fee as identified on the Hearing Aid Dealers database. • ... within the past 365 days is over the maximum fee as identified on the Hearing Aid Dealers database. In the 3rd paragraph, the 1st sentence was revised to read: ... exceed either the maximum payment limit or the standards of coverage ...	Eliminating references to specific dollar amounts which are subject to change

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.22 Observation Care Services	The subsection was re-named to read: Observation Services The following was added at the end of the 1st paragraph: Observation services must also be reasonable and necessary to be covered. The 2nd paragraph was revised to read: ... related to observation services.	To align with Medicare policy reference and to provide clarification
Hospital Reimbursement Appendix	1.3 Status Indicators	In the table in the 2nd paragraph: 1. the "Description" for A1 was revised to read "MDCH covered" and text under "Comments" was removed. 2. addition of "Status Indicator" A6 with "Description" of State Plan Reimbursement	Clarification
Hospital Reimbursement Appendix	4.2.A. Definitions	Definition for OFIR revised to read: ... (OFIR) in the Department of Licensing and Regulatory Affairs (LARA).	Department name change
Hospital Reimbursement Appendix	7.2.B. Small Hospital DSH Pool	The following was added at the end of the 1st paragraph: The FY 2010 allotment for the Small Hospital DSH Pool equaled $7.5 million and was distributed during FY 2011. The FY 2011 allotment for the Small Hospital DSH Pool equals $0.	Reflects legislative changes that occurred during FY 11 but applied to FY 10 amounts. Currently, the pool has $0 allotment for FY 11, but this could change depending on budget decisions.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	7.7.A. Children's Hospital Pool	The 1st paragraph was revised to read: Qualifying children's hospitals will share annually in an outpatient adjuster pool of $1,122,300. In the 3rd paragraph, the 1st sentence was revised to read: The pool of up to $1,122,300 will be distributed ...	Result of SPA approval
Hospital Reimbursement Appendix	8.6 Definitions/Notes	Information for "Hospital's Case Mix" was revised to read: The sum of the relative weights for all Medicaid admissions divided by the number of Medicaid admissions during the period covered.	Description update
Hospital Reimbursement Appendix	8.7 Payment Schedule	The 1st sentence was revised to read: Payments from the GME Funds and the Primary Care Pools will be made quarterly in four equal payments.	Result of SPA approval
Mental Health/ Substance Abuse	1.7 Definition of Terms	Under "Substance Abuse Treatment Specialist", the 2nd bullet point, the top three sub-bullet points were revised to read: ➢ Certified Alcohol and Drug Counselor - Michigan (CADC-M) ➢ Certified Alcohol and Drug Counselor - IC & RC (CADC) ➢ Certified Advanced Alcohol and Drug Counselor - IC & RC (CAADC) Under "Substance Abuse Treatment Practitioner", the definition was revised to read: ... by a Certified Clinical Supervisor - Michigan (CCS-M) or Certified Clinical Supervisor - IC & RC (CCS); or who has ...	IC & RC and MCBAP changed the names of their credentials – this reflects the updated names and acronyms.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	4.3 Essential Elements	Under "Team Composition and Size", 2nd paragraph, the 3rd bullet point, the top four sub-bullet points were revised to read: ➢ Certified Alcohol and Drug Counselor - Michigan (CADC-M) ➢ Certified Alcohol and Drug Counselor - IC & RC (CADC) ➢ Certified Advanced Alcohol and Drug Counselor - IC & RC (CAADC) ➢ Certified Clinical Supervisor - IC & RC (CCS)	IC & RC and MCBAP changed the names of their credentials – this reflects the updated names and acronyms.
Mental Health/ Substance Abuse	Section 11 – Personal Care in Licensed Specialized Residential Settings	In the 2nd paragraph, the 1st sentence was revised to read: ... when authorized by a physician or other health care professional in accordance with ...	Federal case management rule does not permit case managers to authorize services
Mental Health/ Substance Abuse	11.1 Services	The following was added as a 2nd paragraph: "Assisting" means staff performs the personal care tasks for the individual; or performs the tasks along with the individual (i.e., some hands-on); or otherwise assists the individual to perform the tasks himself/herself by prompting, reminding, or by being in attendance while the beneficiary performs the task(s).	Clarifies what is meant by "assisting"
Mental Health/ Substance Abuse	15.1 Waiver Supports and Services	Under "Community Living Supports (CLS)", 1st paragraph, the 1st bullet point was revised to read: • Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with:	Clarification

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Mental Health/ Substance Abuse	15.1 Waiver Supports and Services	Under "Community Living Supports (CLS)", the following was added as a 5th paragraph: Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings or to be provided when the child would typically be in school but for the parent's choice to home-school the child.	Clarification of parental responsibility for minor child related to personal care.
Mental Health/ Substance Abuse	15.1 Waiver Supports and Services	Under "Private Duty Nursing", 1st paragraph, the following was added as the 3rd sentence: PDN services are for beneficiaries who require more individual and continuous care than periodic or intermittent nursing available through state plan services, e.g., Home Health.	Clarification to explicitly state the requirement of 42CFR440.80 per Home and Community-Based Services (HCBS) Technical Guidance from Centers for Medicare & Medicaid Services (CMS) that a waiver service cannot supplant a state plan service.
Mental Health/ Substance Abuse	15.1 Waiver Supports and Services	Under "Private Duty Nursing", under "Medical Criteria III", the following was added at the end of the 5th paragraph: The amount of PDN hours authorized represents a monthly total determined by calculating an average amount of PDN per day multiplied by the number of days in the month. The beneficiary has the flexibility to use the hours as needed during the month, not to exceed the total monthly authorized amount.	Clarification to be consistent with the State Plan PDN policy for beneficiary flexibility in using authorized hours of PDN.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	15.1 Waiver Supports and Services	Under "Private Duty Nursing", under "Medical Criteria III", the following was added as the 6th paragraph: The nurse may provide personal care only when incidental to the delivery of PDN, e.g., diaper changes, but may not provide routine personal care. The provision of personal care in unlicensed homes is through Home Help, a state plan service. If the beneficiary receiving PDN services demonstrates the need for Home Help services, the IPOS must document coordination of Home Help and PDN to assure no duplication of services.	Clarification to explicitly state the requirement of 42CFR440.80 per Home and Community-Based Services (HCBS) Technical Guidance from Centers for Medicare & Medicaid Services (CMS) that a waiver service cannot supplant a state plan service.
Mental Health/ Substance Abuse	17.3.B. Community Living Supports	In the 2nd paragraph, the 1st bullet point was revised to read: • Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding, and/or training in the following activities:	Clarification
Mental Health/ Substance Abuse	Section 17.3.B, Community Living Supports	The following was added as the 5th paragraph: Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings or to be provided when the child would typically be in school but for the parent's choice to home-school the child.	Clarification of parental responsibility for minor child related to personal care.

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Mental Health/ Substance Abuse	17.3.H.1. Peer Specialist Services	In the 1st paragraph, 3rd bullet point, the 6th sub-bullet point was revised to read: ➢ Developing health and wellness plans; In the 1st paragraph, 3rd bullet point, the following sub-bullet points were added: ➢ Integration of physical and mental health care; ➢ Developing, implementing and providing health and wellness classes to address preventable risk factors for medical conditions.	Provides specificity to health and wellness plans and supports roles currently being performed by peers
Mental Health/ Substance Abuse	17.3.H.1. Peer Specialist Services	In the 3rd paragraph, the last sentence was revised to read: Individuals who are working as Peer Support Specialists serving beneficiaries with mental illness must: • have a serious mental illness, • have received public mental health services currently or in the past, • provide at least 10 hours per week of services described above with supported documentation written in the IPOS, and • meet the MDCH application approval process for specialized training and certification requirements.	Clarifies population of mental health recovery and shared experience of public mental health system.
Mental Health/ Substance Abuse	17.3.H.1. Peer Specialist Services	The footnote (associated with the 1st paragraph, 2nd bullet point and the 3rd bullet point, 1st sub-bullet point) was removed.	Not necessary to delineate

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Pharmacy	1.2 Definitions	The term "Federal Drug Rebate Program" was revised to read "Drug Rebate Program". The definition was revised to read: Administered by the Centers for Medicare & Medicaid Services' Center for Medicaid and State Operations. It was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) and requires drug manufacturers to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) for states to receive Federal funding for outpatient drugs dispensed to Medicaid patients. To receive rebates, States must identify the drugs by their national drug code.	Sources: CMS Home > Medicaid > Medicaid Drug Rebate Program > Overview and the abstract from the HHS Office of Inspector General Medicaid Rebates for Physician-Administered Drugs.
Pharmacy	3.2 Enrollment	The 2nd sentence was revised to read: The Pharmacy Provider Enrollment and Trading Partner Agreement (MSA-1626) and the Web Provider Enrollment web-based application are available online at the PBM's website. The MSA-1626 is available for providers who submit paper applications. Web Provider Enrollment is available for providers choosing to enroll paperless.	Incorporates electronic application available 5/20/11.
Pharmacy	Section 19 - Pharmacy Audit and Documentation	In the 3rd paragraph, the 2nd sentence was revised to read: ... discrepancies found through on-site audits and desk audits.	Removal of obsolete information

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Practitioner	1.3 Component Services	In the 3rd paragraph, text after the 1st sentence was revised to read: Services for which the components are covered for the physician are identified in the Practitioner Medical Clinic Database on the MDCH website by the modifier that designates a professional or technical component. In the 4th paragraph, the 1st and 2nd sentences were revised to read: Global services are covered for the physician in non-facility settings or the professional component is covered for the physician in any setting. The technical component is only covered when the service is provided in an appropriate non-facility setting.	Revised for consistency of information in the Billing & Reimbursement for Professionals and the Practitioner chapters
Practitioner	10.1.A. Global/Component Services	The 1st paragraph was revised to read: Global services are covered for the physician in non-facility settings or the professional component is covered for the physician in any setting. The technical component is only covered when the service is provided in an appropriate non-facility setting. The global service and its professional component service cannot both be covered for the same service since the professional component is included in the global service.	Revised for consistency of information in the Billing & Reimbursement for Professionals and the Practitioner chapters
School Based Services	2.2.A. Occupational Therapy Services	Under "Services", the 8th bullet point was revised to read: • Neuromuscular re-education of movement, balance ...	Correction in wording
School Based Services	2.2.C. Assistive Technology Device Services	Under "Services", the 4th bullet point was revised to read: • Neuromuscular re-education of movement, balance ...	Correction in wording

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School Based Services Random Moment Time Study	9.1.B. SAS 70 Audit Requirement	The subsection name was revised to read: SSAE 16 Audit Requirements All references to "Statement of Accounting Standards (SAS) 70" were revised to read "Statement on Standards for Attestation Engagements (SSAE) 16". The 2nd paragraph was revised to read: In a SSAE 16 type 2 engagement, the service auditor expresses an opinion on whether the description of the service organization's system is fairly presented, whether the controls included in the description are suitably designed, whether the controls were operating effectively, and provides a description of the service auditor's tests of operating effectiveness and the results of those tests.	Per Office of Audit direction
Acronym Appendix		deleted: DELEG added: LARA - (Department of) Licensing and Regulatory Affairs	General update
Directory Appendix	Prior Authorization	1) Under "Program Review Division", text for "Information Available/Purpose" was revised to read: Prior authorization for all services, except hospital and pharmacy. 2) Under "Prior Authorization - Dental", the phone number 517-335-5090 was removed. 3) Contact/Topic title for "Prior Authorization - DME" was revised to read "Prior Authorization - Specified DME Equipment and Medical Supplies" and text for Information Available/Purpose was revised to read "Prior authorization of specified DME equipment ..."	1) Reference to "dental" no longer applicable 2) Obsolete information 3) update/consistency in wording
Directory Appendix	School Based Services	References to "SAS 70 audit" were revised to read "SSAE 16 Audit". E-mail addresses were revised to read: MSAPolicy@michigan.gov	Per Office of Audit direction; General update

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 11-16	5/1/2011	General Information for Providers	Section 2 - Provider Enrollment	The following was added as the 4th paragraph: MDCH is prohibited by federal law from issuing Medicaid payment to any financial institution or entity whose address is outside of the U.S.
			7.3 Out of State/Beyond Borderland Providers	The following was added as the 6th paragraph: MDCH is prohibited by federal law from issuing Medicaid payment to any financial institution or entity whose address is outside of the U.S.
MSA 11-06	3/1/2011	Billing & Reimbursement for Institutional Providers	1.1 Claims Processing System	The following was added at the end of the 2nd paragraph: MDCH uses the Medicaid National Correct Coding Initiative (NCCI) policies and edits. (Refer to the Directory Appendix for resource information.)
		Billing & Reimbursement for Professionals	1.1 Claims Processing System	The following was added at the end of the 2nd paragraph: MDCH uses the Medicaid National Correct Coding Initiative (NCCI) policies and edits. (Refer to the Directory Appendix for resource information.)
		Billing & Reimbursement for Professionals	6.14 Maternity Care Services	Under ""Coding" and under "Global Services", "CCI" was revised to read "Medicaid NCCI."
		Hospital	3.29.A Operating Room	In the 2nd paragraph, 3rd sentence, "CCI" was revised to read "Medicaid NCCI."

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 11-06	3/1/2011	Hospital Reimbursement Appendix	1.2 Outpatient Code Editor with Ambulatory Payment Classification	In the 1st paragraph, 1st sentence, "Correct Coding Initiative (CCI)" was revised to read "Medicaid National Correct Coding Initiative (NCCI)."
		Practitioner	1.13 Uniform Reporting of Services	Subsection text was revised in its entirety and reads: MDCH follows the American Medical Association's manual and guidelines for Current Procedural Terminology (CPT) numeric codes, and the Healthcare Common Procedure Coding System (HCPCS). In conjunction with the CPT/HCPCS coding systems to describe services rendered, MDCH utilizes the Medicaid National Correct Coding Initiative (NCCI) coding policies and edits as developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies.
			8.4 Obstetrical Package vs. Components	In the 1st paragraph, 4th sentence, "CCI" was revised to read "Medicaid NCCI."
		Acronym Appendix		Removal of "Medicare Correct Coding Initiative" from the meaning of "CCI." Addition of "NCCI", with meaning of "Medicaid National Correct Coding Initiative."
		Directory Appendix	Billing Resources	The following information line was added: **Contact/Topic:** Medicaid National Correct Coding Initiative (NCCI) **Phone #/Fax #:** Fax 317-571-1745 **Mailing/Email/Web Address:** Medicaid National Correct Coding Initiative Correct Coding Solutions, LLC P.O. Box 907 Carmel, IN 46082-0907 www.cms.gov/MedicaidNCCICoding

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				Information Available/Purpose: Information regarding Medicaid NCCI. Questions regarding NCCI coding policies and edits may be directed to the CMS NCCI Contractor: Correct Coding Solutions, LLC.
MSA 11-04	2/16/11	General Information for Providers	Section 18 - Electronic Health Record (EHR) Incentive Program	The following was added as the 8th paragraph: Information specific to the Hospital EHR Incentive Program can be found in the Hospital Reimbursement Appendix Chapter of the Provider Manual.
		Hospital Reimbursement Appendix	Section 13 - Electronic Health Record (EHR) Incentive Program for Hospitals (new section)	New section text reads: The Health Information Technology for Economic and Clinical Health Act (HITECH), enacted as part of the American Recovery and Reinvestment Act of 2009, authorized incentive payments through Medicare and Medicaid to eligible hospitals as they adopt, implement, and/or upgrade, or demonstrate meaningful use of certified Electronic Health Record (EHR) technology. The hospital incentive program is designed to support hospitals in a period of health information technology transition and instill the use of EHRs in meaningful ways to help improve the quality, safety, and efficiency of patient health care. The purpose of EHRs and meaningful use is to: • Improve quality, safety, efficiency, and reduction of health disparities; • Engage patients and families in their health care; • Improve care coordination; • Improve public health; and • Ensure adequate privacy and security protections for personal health information.

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			13.1 Registration and Interfaces with the National Level Repository	All hospitals seeking an EHR incentive payment are required to register with the National Level Repository (NLR). The NLR is the federal database which verifies basic provider information prior to notifying State Medicaid programs of a provider's intent to participate in the Medicare and Medicaid EHR Incentive Program. To register with the NLR, all Eligible Hospitals (EHs) must have a National Provider Identifier (NPI) and be enrolled in the CMS Provider Enrollment, Chain, and Ownership System (PECOS). Registration requires an active user account in the National Plan and Provider Enumeration System (NPPES). Note that any revisions to information provided in the NLR must be modified at the NLR level. The Michigan Department of Community Health (MDCH) is notified upon successful registration with the NLR. EHs are directed to the Michigan Medicaid Community Health Automated Medicaid Processing System (CHAMPS) to begin the Michigan Medicaid EHR registration process. The EHR Incentive Program module was created within the CHAMPS system to collect and record EH data. All providers have up to 30 days from MDCH receipt of the NLR file to submit completed registration information in the CHAMPS EHR module. Failure to do so in the allotted time frame could require hospitals to re-register at the NLR level. Providers must be an enrolled Michigan Medicaid provider and have an active Payee-Tax Identification on record within the Michigan Treasury MAIN system. EHs are only required to register once for the Medicare and Medicaid EHR Incentive Programs. However, they must successfully demonstrate that they have adopted, implemented and/or upgraded (first participation year for Medicaid) or meaningfully used certified EHR technology each year in order to receive an incentive payment for that year. Additionally, providers seeking the Medicaid incentive must annually re-attest to other program requirements, such as meeting the required patient volume thresholds. Following EH data collection in the NLR and Medicaid EHR CHAMPS module, EH eligibility determinations are calculated. Following a successful eligibility determination, EH payments are calculated. A final report is filed with the NLR following a processed EHR incentive payment.
			13.2 Requirements for Participation	In order to participate in the Michigan Medicaid EHR Incentive Program, hospitals must be a Medicaid enrolled provider and have a completed Medicaid Quarterly Report, Medicaid Cost Report (MMF) and CMS 2552 Cost Report on file with MDCH that correlates with the specified timeframe from which data are pulled. In an effort to have the most complete and accurate information for program calculations, all revisions, amendments, and modifications to data sources used in eligibility and payment calculations must be complete prior to hospital registration in the EHR Incentive Program. Incomplete data sources or data that is under revision are not utilized; therefore, hospital eligibility determinations and payment calculations could be delayed as a result.

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				Hospitals must review and agree to the attestation requirements outlined in the Michigan Medicaid EHR CHAMPS module. EHs select their EHR status (e.g., Adopt, Implement, and/or Upgrade or Meaningful Use) and provide their EHR certification number. EHs attest that the information they are providing is true, accurate, and complete. EHs may participate in both the Medicare EHR Incentive Program and the Medicaid EHR Incentive Program. Hospitals must choose only one state from which to register and receive a Medicaid EHR incentive payment.
			13.3 Eligible Hospitals Defined	Per CMS, eligible hospitals are defined as follows: • Acute care hospitals (includes critical access hospitals [CAH]) and cancer hospitals meeting the following requirements: ➢ A health care facility where the average length of patient stay is 25 days or fewer, ➢ CMS Certification Number (CCN) ending between 0001 and 0879 or 1300-1399, and ➢ Meet a Medicaid patient volume threshold of at least 10%; **or** • Children's hospitals (does not include children's wings of larger hospitals) which are separately certified children's hospitals with CCN ending between 3300 and 3399. Children's hospitals do not have to meet a minimum Medicaid patient volume threshold.
			13.4 Eligibility Verification	To verify hospital eligibility, data reported on the CMS 2552, Medicaid Quarterly Report, and the MMF are utilized. Eligibility requirements are calculated annually upon registration in the Medicaid EHR Incentive Program. Hospitals should confirm that all necessary data elements are complete and reported for EHR incentive calculation purposes.
			13.4.A. Average Length of Stay (LOS)	Average LOS is calculated by reviewing the current CMS 2552 Cost Report and MMF report on file with MDCH. The following calculation is used: Total Inpatient Days/Total Inpatient Discharges = Hospital Average LOS

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			13.4.B. Medicaid Eligible Patient Volume	A hospital's Medicaid eligible patient volume is calculated using the Medicaid Quarterly Report. Acute care hospitals must annually meet a 10% Medicaid eligible patient volume threshold to participate in the EHR Incentive Program. EH Medicaid eligible patient volumes are verified each year of a hospital's participation in the EHR Incentive Program. (Children's hospitals are exempt from the volume threshold requirement.) MDCH selects the hospital quarter (90-day continuous period) from the prior calendar year from the hospital EHR registration date to derive the Medicaid eligible patient volume data. For purposes of measuring Medicaid eligible patient volume, an inpatient hospital day or hospital discharge is considered as an encounter. One of two calculation methods is utilized to determine Medicaid eligible patient volume. The quarter of the prior calendar year and calculation method that yields greater Medicaid eligible patient volume is utilized to determine hospital eligibility. Patient encounters include both Fee-for-Service (FFS) and Managed Care Organization (MCO) data. One of the following calculations will be utilized to determine Medicaid Patient Volume: Total Medicaid Hospital Days **X** 100 **=** Medicaid Patient Volume Total Hospital Days **OR** Total Medicaid Hospital Discharges **X** 100 **=** Medicaid Patient Volume Total Hospital Discharges
			13.5 Incentive Payment Calculation	EHR Incentive Program payments are calculated in accordance with the formula outlined in the HITECH under Section 495.310. Payments are made over a total of three years and are paid 50% of the aggregate calculation in the first year, 40% in the second year, and 10% in the third year.

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			13.5.A. Timing	EHs that adopt, implement, and/or upgrade a certified EHR system or are meaningful users can begin receiving incentive payments in any year from fiscal year (FY) 2011 to FY 2016. The Medicaid EHR Incentive Program operates on the Federal Fiscal Year (FFY) (October 1 through September 30) calendar. While the statute defines a payment year in terms of a FFY, a hospital does not have to begin receiving incentive payments in FY 2011. However, the last year a hospital can first receive an initial Medicaid incentive program payment is FY 2016. EHs are paid up to 100% of the calculated aggregate EHR hospital incentive payment amount over a three-year period. Data utilized to calculate the aggregate EHR hospital incentive amount is derived from filed hospital cost reports (CMS 2552 and MMF) from the hospital fiscal year that ends during the FFY prior to the hospital fiscal year that serves as the first payment year. All revisions, amendments, and modifications to data sources must be completed prior to a hospital's registration for the EHR Incentive Program. This includes revisions to the filed cost reports (CMS 2552 and MMF) used to calculate the aggregate EHR incentive amount. Incomplete hospital data sources will result in delays in eligibility determinations and payment calculations.
			13.5.B. Payment Formula	The aggregate EHR incentive amount is a one-time calculation based upon the sum of a theoretical four-year calculation period where the amount of each year is the product of the following factors: • the overall EHR amount; and • the Medicaid Share. The overall EHR amount is also based upon the sum over a theoretical four-year calculation period where the amount of each year is the product of two factors: • an Initial Amount; and • the Transition Factor applicable to each of the four years. (All data used in the payment calculation is derived from the same 12 month cost report period, other than discharge data used to calculate the annual growth rate.)

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Initial Amount and Theoretical Four-Year Calculation Period The Initial Amount is the sum of a base amount and a discharge-related amount. The base amount is $2,000,000, and the discharge-related amount provides an additional $200 for estimated discharges between 1,150 and 23,000. No discharge-related amount is made for discharges prior to the 1,150th discharge or for discharges after the 23,000th discharge. For the first calculation year, data on hospital discharges from the hospital fiscal year that ends during the FFY prior to the hospital fiscal year that serves as the first payment year is used as the basis for determining the discharge-related amount. To determine the discharge-related amount for the three subsequent theoretical calculation years, the number of discharges is based on the average annual growth rate for the hospital over the most recent three years of available data. The growth rate is based on a three-year average of total discharges, beginning with the initial calculation year and including data from the three prior years. The annual growth rate is applied to the base year's discharges to arrive at the three subsequent year discharge amounts. If an EH's average annual rate of growth is negative over the three-year period, the rate is applied as such. Transition Factor For each of the four years of the calculation, a different transition factor applies. The aggregate Medicaid EHR Incentive Payment is calculated once and is then distributed over three actual payment years. The transition factors listed below are used to calculate the aggregate EHR amount but do not indicate that hospital payments will be recalculated on a yearly basis.

Theoretical Calculation Period	Transition Factor
Year 1	1.00
Year 2	0.75
Year 3	0.50
Year 4	0.25

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Medicaid Share The Medicaid Share is the percentage of a hospital's inpatient, non-charity care days that are attributable to Medicaid inpatients. The numerator of the Medicaid Share is the sum of: • The estimated number of Medicaid inpatient-bed-days; and • The estimated number of Medicaid managed care inpatient-bed-days. The denominator of the Medicaid Share is the product of: • The estimated total number of inpatient-bed-days for the eligible hospital during that period; and • The estimated total number of the eligible hospital's charges during that period, not including any charges that are attributable to charity care, divided by the estimated total amount of the hospital's charges during that period. For the purposes of the EHR incentive payment calculation, charity care is calculated using data from the MMF Indigent Volume Form as follows: (Total Uncompensated Charges **–** Third Party Bad Debts **–** Uninsured Payments from Charges **–** Recoveries for Uninsured Bad Debt) **=** Charity Care The removal of charges attributable to charity care in the formula, in effect, increases the Medicaid Share resulting in higher incentive payments for hospitals that provide a greater proportion of charity care.

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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>
<u>Payment Calculation Summary</u>
<table>
<tr><td>1. Calculate initial amount</td><td>$2 million base amount + ((discharge bonus)*200) = initial amount
$200 per total discharge between 1,150 and 23,000</td></tr>
<tr><td>2. Calculate four theoretical years</td><td>Year 1: 100% of initial amount
Year 2: 75% of initial amount (+ or – any change in discharge level based on annual growth rate)
Year 3: 50% of initial amount (+ or – any change in discharge level based on annual growth rate)
Year 4: 25% of initial amount (+ or – any change in discharge level based on annual growth rate)</td></tr>
<tr><td>3. Sum four theoretical year calculations</td><td>Year 1 + Year 2 + Year 3 + Year 4 = Aggregate Hospital EHR Incentive Amount</td></tr>
<tr><td>4. Calculate Medicaid Share</td><td>Medicaid inpatient days / (total inpatient days * ((gross revenue – charity) / gross revenue))</td></tr>
<tr><td>5. Multiply Aggregate Hospital EHR Incentive Amount by Medicaid Share</td><td>Aggregate Hospital EHR Amount * Medicaid Share = Total Hospital EHR Incentive Amount</td></tr>
<tr><td>6. Paid over three payment years</td><td>Payment Year 1 = 50% of Total Hospital EHR Incentive Amount
Payment Year 2 = 40% of Total Hospital EHR Incentive Amount
Payment Year 3 = 10% of Total Hospital EHR Incentive Amount</td></tr>
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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			13.6 Payment Notification and Gross Adjustments	EH Medicaid Incentive payments are made annually via gross adjustment. EHs cannot receive more than one incentive payment in each State fiscal year. Following the verification of hospital eligibility, an incentive payment is calculated and the EH is notified of the final amount. EHs have up to 30 days from receiving their payment notice to dispute payment calculations. If no communication is received or the EH agrees with the payment notice, the incentive payment is processed via gross adjustment in the CHAMPS system.
			13.7 Adopt, Implement, and/or Upgrade or Meaningful Use	To receive a first year's incentive payment, EHs must attest to adopting, implementing, and/or upgrading (AIU) a certified EHR system. EHs are required to provide the certification number of their EHR system within the EHR CHAMPS module during registration as part of AIU attestation. Eligible Medicaid hospitals can receive their first year's payment for AIU attestation and not meaningful use, but must meet the meaningful use requirement in all subsequent participation years. If an EH is eligible for both Medicare and Medicaid EHR Incentive Programs and has achieved meaningful use standards under Medicare, they are recognized as a meaningful user for Medicaid purposes. In order to continue to receive incentive payments after the first payment year, providers must achieve and maintain a set of meaningful use measures as defined by CMS. Meaningful use employs a three-stage approach, with each stage building on the preceding stage: • Stage 1 – Data capture and sharing • Stage 2 – Expand on Stage 1 criteria to encourage the use of health information technology for continuous quality improvement • Stage 3 – Expand on Stage 2 with a focus on promoting outcomes in quality, safety, and efficiency To demonstrate Stage 1 of meaningful use, an EH must comply with a set of "core" requirements and a selection of "menu" requirements. MDCH has adopted the same requirements outlined by CMS without modification.

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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
06/01/2011	MSA 11-24	Sanctioned Providers Update	All Providers	
06/01/2011	MSA 11-23	Payment Adjustments for Practitioner Services Provided Through Designated Public Entities	Practitioners, Dentists, Hospitals (Inpatient, Outpatient), Optometrists	
06/01/2011	MSA 11-22	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	
06/01/2011	MSA 11-21	Medicaid Non-Payment and Reporting Requirements for Provider Preventable Conditions	All Providers	
06/01/2011	MSA 11-20	Medicaid Estate Recovery	Bridges Eligibility Manual Holders	

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DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	COMMENTS
06/01/2011	MSA 11-19	Revisions to Mental Health/Substance Abuse Chapter, Section 7 - Home-Based Services	Prepaid Inpatient Health Plans (PIHP) and Community Mental Health Service Providers (CMHSP)	
06/01/2011	MSA 11-14	Medicaid Coverage of Tobacco Cessation for Pregnant Women	All Providers	
05/10/2011	MSA 11-17	Change in Acquisition Cost Definition	Hospitals, Physicians, Durable Medical Equipment, Prosthetics, Orthotics, and Suppliers, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers	
03/31/2011	MSA 11-15	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	
03/22/2011	MSA 11-13	Correction to MSA 11-08	Hospitals, Medicaid Health Plans	
03/01/2011	MSA 11-12	Claims for Immunizations	Local Health Departments, Medicaid Health Plans	

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DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	COMMENTS
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 Centers, 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 Centers, Rural Health Clinics, Tribal Health Centers	
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	
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.

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DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	COMMENTS
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