MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 11-47

Distribution: All Providers

Issued: December 1, 2011

Subject: Updates to the Medicaid Provider Manual;
MDCH Website and Provider Databases/Fee Screens;
5010 Update; Voluntary Enrollment of Dual Eligibles Into Medicaid Health Plans

Effective: January 1, 2012

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 2012 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 2012 version of the Manual does not highlight changes made during the past year (2011). 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 2012 versions of the manual will be highlighted within the text of the on-line manual.

MDCH Website and Provider Databases/Fee Screens

The Provider Specific Information page on the MDCH website has been redesigned to allow additional provider groups to be posted. Information includes databases/fee screens, database-specific instructions for use, and supplemental reference documents. A revised database format has been applied to inform providers of code changes implemented since the last published version. Refer to the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Databases/fee screens are updated on an annual basis or more frequently if necessary (e.g., quarterly updates). A three-year history is maintained on this site. For databases/fee screens prior to 2009, providers should submit an e-mail to msapolicy@michigan.gov.

Providers are instructed to refer to the Michigan Medicaid Provider Manual and/or MSA bulletins for specific details on coverages, reimbursement policies, and/or required forms. This information is available on the MDCH website at www.michigan.gov/medicaidproviders >> Policy and Forms.

5010 Update

Health Insurance Portability and Accountability Act (HIPAA) 5010 transaction standards will be effective January 1, 2012. Providers who have not been certified for submission of HIPAA 5010 transactions should complete testing immediately to prevent claim rejections in January 2012. Testing instructions, a list of certified

trading partners, and other pertinent information is located on the MDCH website at www.michigan.gov/5010icd10. It is essential that all providers ensure that their vendor, trading partner or clearinghouse can support 5010 and have completed Stage 1 and Stage 2 Business-to-Business (B2B) testing.

Changes to the Community Health Automated Medicaid Processing System (CHAMPS) Direct Data Entry (DDE) for online claims submission have also been made. New templates can be created once you access the DDE as templates used for submitting 4010 claims will no longer be available.

Watch the MDCH website for additional information on conversion to the 5010 transaction standards.

Voluntary Enrollment of Dual Eligibles into Medicaid Health Plans

Bulletin MSA 11-37 announced that MDCH transitioned Medicaid beneficiaries with both Medicare eligibility and Medicaid eligibility (dual eligibles) from an excluded population to a voluntary population for purposes of Medicaid Health Plan (MHP) enrollment. The following dual eligibles will remain an excluded population:

- Dual eligibles with Program Code C, L, N, or Q,
- Dual eligibles excluded for reasons other than dual eligible status, such as Medical Exception or Incarceration, and
- Dual eligibles enrolled in a Medicare Managed Care Plan (MMCP) if that MMCP is not approved to serve Medicaid enrollees in the enrollee's county of residence.

As stated in the bulletin, the initiation of this enrollment process was subject to approval from the Centers for Medicare and Medicaid Services (CMS). MDCH formally received approval to begin this process from CMS on October 31, 2011. Dual eligibles have begun the process of voluntary enrollment into the MHPs with an effective enrollment date of December 1, 2011.

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.

Approved

Stephen Fitton, Director
Medical Services Administration

Michigan Department of Community Health

Medicaid Provider Manual
January 2012 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		Editing was made relative to revisions to databases and fee screens. Edits include, but are not limited to, changes in database/fee screen titles, format details, and consistency in terminology.	
Throughout the Manual		Due to name changes: ▪ "Hospital & Health Plan Reimbursement Division" has been revised to read "Hospital and Clinic Reimbursement Division" ▪ "HHPRD" has been revised to read "HCRD" ▪ "Special Programs Section" has been revised to read "Settlement Section"	
General Information for Providers	12.3 Billing Limitation	In the 2nd paragraph, the 1st bullet point was revised to read: ▪ For inpatient hospitals, nursing facilities, and MHPs, it is the "To" or "Through" date indicated on the claim.	Clarification.

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

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	Section 2 - mihealth Card	The 7th paragraph was revised to read: ... the provider can also access the beneficiary's eligibility information with the following additional search methods: ▪ Member ID/Client Identification Number (CIN)/Pending Eligibility Recipient Identification (RID). ▪ Last Name, First Name and Date of Birth. ▪ Last Name, First Name and Social Security Number (SSN). ▪ SSN and Date of Birth. Additional search options (use if needed with one of the search options above to obtain a unique member match): ▪ Gender ▪ Zip Code ▪ Case Number	5010 update.

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

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	3.1 CHAMPS Eligibility Inquiry	In the 3rd paragraph, the following text was added to the 6th bullet point: NOTE: The 270/271 response will report up to eight (8) diagnosis codes for a single date of service. Refer to CHAMPS Eligibility Inquiry to obtain all approved diagnosis codes if more than eight (8) diagnosis codes exist for the date of service. and the 7th bullet point was revised to read: ▪ ... and DHS local office phone number In the 4th paragraph (under "Notes"), the following was added to the 1st bullet point: Note: The CHAMPS Eligibility Inquiry and 270/271 response will report "FFS Dental" for Medicaid, Healthy Kids Expansion, and TMA-Plus beneficiaries who have Fee For Service Dental. In the 4th paragraph, the following was added as a 3rd bullet point: ▪ The CHAMPS Eligibility Inquiry and 270/271 response will report the HIPAA Service Type description or code for general services covered under each Benefit Plan and any applicable copay amounts. This is general information only. Always refer to the applicable chapters in this Manual to obtain detailed information on all covered services, including PA requirements, copay amounts/exclusions, and other requirements for the Benefit Plan ID(s) reported in the eligibility response.	5010 update.

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

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	10.2 Identifying CSHCS on the CHAMPS Eligibility Inquiry	In the 1st paragraph, the following was added to the 1st bullet point: Note: The 270/271 response will report up to eight (8) diagnosis codes for a single date of service. Refer to CHAMPS Eligibility Inquiry to obtain all approved diagnosis codes if more than eight (8) codes exist for the date of service.	5010 update.
Billing & Reimbursement for Dental Providers	5.2 Loss or Change in Eligibility	The 3rd paragraph was revised to read: For services due to loss or change in eligibility: • Complete or partial dentures, laboratory-processed crowns, and/or root canal therapy must have been started prior to the change/loss of eligibility and completed within 30 days of the date of the change/loss of eligibility. ➢ DDE claims: • Treatment Start Date and Treatment Completion Date are required within the appropriate fields. ➢ Paper claims: • For complete or partial dentures and laboratory-processed crowns, the date of service on the claim should be the date of the initial impression (the completion date must be supplied in the Remarks section). • For root canal therapy, the date of service should be the first treatment appointment (the completion date must be supplied in the Remarks Section).	Due to the implementation of the HIPAA X12 version 5010, the treatment start and completion dates are now required for electronic claims when billing for these services.

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

Medicaid Provider Manual
January 2012 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Dental Providers	5.4 Diagnosis Reporting (new subsection; following subsections re-numbered)	New subsection text reads: For DDE claims, the diagnosis code for all oral and maxillofacial surgeries and/or anesthesiology services is required to be reported in the applicable diagnosis field. For paper claims, the diagnosis must be reported in the Remarks Section.	Due to implementation of the HIPAA X12 version 5010, the appropriate diagnosis code for electronic claims must be reported for oral-maxillofacial surgery and/or anesthesiology services.
Billing & Reimbursement for Dental Providers	5.5 Quantity (new subsection; following subsection re-numbered)	New subsection text reads: For DDE claims, the Quantity field is also available for users to report the number of services rendered.	Quantity can be reported for electronic and DDE dental claims. No changes for paper claims.
Billing & Reimbursement for Dental Providers	8.1 Payments/Claim Status	Subsection was renamed "Payment Process".	Clarification of title as MDCH payment process is described.
Billing & Reimbursement for Dental Providers	8.5 Paid or Rejected Claims	Subsection was renamed "Claim Adjustment Reason/Remark Codes".	Clarification of title as Claim Adjustment Reason and Remittance Advice Remark Codes are reported on the RA to identify paid or rejected services.

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

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	7.18.A. Electronic Claims	The 3rd paragraph was revised to read: To bill a procedure code (HCPCS or CPT) with multiple NDCs (including compounded drugs): ▪ Repeat the HCPCS code on multiple service line loops, allowing one NDC to be reported within each LIN segment. ▪ Within the LIN segment, report the 11-digit NDC, description of the drug, route of administration, Unit of Measurement Value Code, and NDC price. ▪ For the REF segment, the prescription number must be reported on each service line to link this service together.	Due to implementation of the HIPAA X12 version 5010, only one LIN segment is used to report the supplemental NDC information along with the HCPCS code. For electronic and DDE claims, the prescription number must be reported to link multiple service lines together for the same procedure code. No changes for paper claims.
Billing & Reimbursement for Institutional Providers	12.1 Payments/Claim Status	Subsection was renamed "Payment Process".	Clarification of title as MDCH payment process is described.
Billing & Reimbursement for Institutional Providers	12.5 Paid or Rejected Claims	Subsection was renamed "Claim Adjustment Reason/Remark Codes".	Clarification of title as Claim Adjustment Reason and Remark Codes are reported on the RA to identify paid or rejected services.
Billing & Reimbursement for Professionals	Section 3 - Claim Completion	In the chart, under Explanation for Item 24F, the 2nd, 3rd, and 4th paragraphs were deleted.	Obsolete information

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Professionals	6.4 Ancillary Medical Services	Under "National Drug Code (NDC) Reporting for Physician Administered Drugs", the following text was inserted after the paragraph for "Electronic Claims": DDE Claims: To report a procedure code with multiple NDCs (e.g., compound drug), the same HCPCS code must be repeated on multiple service lines, allowing each NDC to be reported. The prescription number must be reported on each service line to link this service together as one compound drug.	Due to implementation of the HIPAA X12 version 5010, only one LIN Segment is used to report the supplemental NDC information along with the HCPCS code. For electronic and DDE claims, the prescription number must be reported to link multiple service lines together for the same procedure code. No changes for paper claims.
Billing & Reimbursement for Professionals	8.1 Payments/Claim Status	Subsection was renamed "Payment Process".	Clarification of title as MDCH payment process is described.
Billing & Reimbursement for Professionals	8.5 Paid or Rejected Claims	Subsection was renamed "Claim Adjustment Reason/Remark Codes".	Clarification of title as Claim Adjustment Reason and Remark Codes are reported on the RA to identify paid or rejected services.
Dental	9.2 Enrollment Information	The following was added as the 3rd paragraph: The CHAMPS Eligibility Inquiry and 270/271 response will report "FFS Dental" for Medicaid, Healthy Kids Expansion and TMA-Plus beneficiaries who have Fee For Service Dental.	5010 update.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hearing Aid Dealers	2.6.D. Payment Rules	Text was revised to read: Refer to the Hearing Aid Dealers database on the MDCH website for payment rules regarding hearing aid supply and accessory replacement.	Addresses time-sensitive material which is maintained on the MDCH website.
Hospital	6.5 Home and Community Based Waiver for the Elderly and Disabled (MI Choice Waiver Program)	In the 1st paragraph, the 1st sentence was revised to read: The beneficiary must meet the eligibility criteria in the Michigan Medicaid Nursing Facility Level of Care Determination and at least one waiver service.	Clarification
Hospital	6.6 Program of All-Inclusive Care for the Elderly (PACE)	Subsection text was revised to read: The Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) must be completed for every Medicaid beneficiary prior to admission to the PACE. The PACE agent must verify beneficiary appropriateness for services by completing the online version of the LOCD. Beneficiaries who do not demonstrate functional/medical eligibility through the online LOCD are not eligible for PACE. Information regarding the LOCD process, the LOCD assessment, and the LOCD Field Definition Guidelines is on the MDCH website. (Refer to the Directory Appendix for website information.) While the PACE agency is the actual entity that must complete and conduct the online LOCD, hospitals are encouraged to assess a beneficiary's functional/medical eligibility for PACE using a hard copy of the LOCD. A hospital may also use the Telephone Intake Guidelines. The Guidelines are also available on the MDCH website.	Clarification

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

CHAPTER	SECTION	CHANGE	COMMENT
Hospital	6.8 Nursing Facility	In the 3rd paragraph, the 5th bullet point was revised to read: ▪ A Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) must be completed for every Medicaid beneficiary prior to admission to a nursing facility. The nursing facility must verify beneficiary appropriateness for nursing facility care by completing the online version of the LOCD. Beneficiaries who do not demonstrate functional/medical eligibility through the online LOCD are not eligible for nursing facility care. Refer to the Coverages portion of the Nursing Facility Chapter for additional information regarding the LOCD. While the nursing facility is the actual entity that must complete and submit the LOCD, hospitals are encouraged to assess a beneficiary's functional/medical eligibility for nursing facility care using a hard copy of the LOCD. A hospital may also use the Telephone Intake Guidelines. The Guidelines are also available on the MDCH website.	Clarification
Hospital Reimbursement Appendix	Section 10 - Audits	The 2nd sentence was deleted.	Obsolete information.
Hospital Reimbursement Appendix	10.1 Desk Audit	The 4th bullet point was deleted.	Obsolete information.
Hospital Reimbursement Appendix	10.2 Field Audit	Subsection was deleted; following subsection was re-numbered.	Obsolete information.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Medical Supplier	1.7.H Reimbursement Amounts	In the 1st paragraph, the 3rd sentence was revised to read: For items that do not have established fee screens or are custom fabricated, refer to the MDCH Medical Supplier/DME/Prosthetics and Orthotics Database Instructions posted on the MDCH website for payment rules. (Refer to the Directory Appendix for website information.)	Addresses time-sensitive material which is maintained on the MDCH website.
Mental Health/ Substance Abuse	3.12 Inpatient Psychiatric Hospital Admissions (new subsection; following subsections re-numbered)	New subsection text reads: Refer to the Inpatient Psychiatric Hospital Admissions Section of this chapter for specific program requirements.	Added as reference/clarification as a covered service.
Mental Health/ Substance Abuse	3.19 Outpatient Partial Hospitalization Services (new subsection; following subsections re-numbered)	New subsection text reads: Refer to the Outpatient Partial Hospitalization Services Section of this chapter for specific program requirements.	Added as reference/clarification as a covered service.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	12.1 Covered Services - Outpatient Care	The 2nd and 3rd paragraphs were revised to read: Outpatient treatment is a non-residential treatment service that can take place in an office-based location with clinicians educated/trained in providing professionally directed alcohol and other drug (AOD) treatment or a community-based location with appropriately educated/trained staff. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week but, when medically necessary, can total over 20 hours in a week. Individual, family or group treatment services may be provided individually or in combination. Treatment must be individualized based on a bio-psycho-social assessment, diagnostic impression and beneficiary characteristics, including age, gender, culture, and development. Authorized decisions on length of stay, including continued stay, change in level of care, and discharge, must be based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. Beneficiary participation in referral and continuing care planning must occur prior to discharge and should be based on the needs of the beneficiary in order to support sustained recovery.	To clarify that outpatient services are allowed to be provided in a community-based setting. To clarify that continuing care service referrals are to be used to support sustained recovery.

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

CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	12.1.B. Covered Services	In the chart, the following revisions were made: <u>Individual Assessment</u> A face-to-face service for the purpose of identifying functional, treatment and recovery needs and a basis for formulating the Individualized Treatment Plan. <u>Referral/Linking/Coordinating/Management of Service Needs</u> For the purpose of ensuring follow-through with identified providers, providing additional support in the community if primary services are to be provided in an office setting, addressing other needs identified as part of the assessment and/or establishing the beneficiary with another provider and/or level of care. This service may be provided individually or in conjunction with other services based on the needs of the beneficiary (frequently referred to as substance use disorder case management). <u>Peer Recovery and Recovery Support</u> To support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Peer recovery programs are designed and delivered primarily by individuals in recovery (Recovery Coach) and offer social, emotional, and/or educational supportive services to help prevent relapse and promote recovery. <u>Substance Abuse Treatment Services</u> Services that are required to include assessment, treatment planning, stage-based interventions, referral linking and monitoring, recovery support preparation, recovery support services, and treatment based on medical necessity. They may include individual, group and family treatment. These services are provided under the supervision of a SATS or SATP.	To clarify that the individual assessment needs are to also focus on recovery needs. ***** To clarify how referral/linking/coordinating and management of service needs can be carried out. ***** To clarify that these services are provided by a recovery coach. ***** To clarify that recovery support services are a component of overall substance abuse treatment.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	Section 14 - Children's Home and Community-Based Services Waiver (CWP)	In the 1st paragraph, the 2nd sentence was deleted.	Obsolete information
Mental Health/ Substance Abuse	15.1 Waiver Supports and Services	In the table, under "Supports Coordination", the 8th paragraph was revised to read: Supports Coordination is reported only when there is face-to-face contact with the beneficiary. Related activities, such as telephone calls to schedule appointments or arrange supports, are functions that are performed by a supports coordinator but not reported separately. Supports coordination functions must assure:	Per MDCH response to Auditor General finding
Mental Health/ Substance Abuse	17.3.H.1. Peer Specialist Services	In the 1st paragraph, the 1st sentence was revised to read: Peer specialist services provide individuals with opportunities to support, mentor and assist beneficiaries to achieve ...	Typo correction

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

CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	17.3.J. Respite Care Services	In the 1st paragraph, the 1st sentence was revised to read: Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided 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. The following text was added after the 1st paragraph: • "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 a time period 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.	Clarification.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	17.3.L. Support and Service Coordination	The 7th paragraph was revised to read: Supports Coordination is reported only when there is face-to-face contact with the beneficiary. Related activities, such as telephone calls to schedule appointments or arrange supports, are functions that are performed by a supports coordinator but not reported separately. Supports coordination functions must assure:	Per MDCH response to Auditor General finding
Nursing Facility Coverages; Nursing Facility Certification, Survey & Enforcement Appendix; Nursing Facility Cost Reporting & Reimbursement Appendix	throughout	Due to re-organization of Departments within the State of Michigan, some responsibilities formerly carried out by the Michigan Department of Community Health (MDCH) are now performed by the Michigan Department of Licensing and Regulatory Affairs (LARA). Updates were made to reflect the correct Department.	General update.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.11.B. Nurse Aide Training and Competency Evaluation Program (NATCEP) Add-on	The textbox after the 2nd paragraph was deleted.	Dated information.

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

CHAPTER	SECTION	CHANGE	COMMENT
Program of All-Inclusive Care for the Elderly	3.1 Eligibility Requirements	The 6th bullet point was revised to read: ▪ A determination of functional/medical eligibility based upon the online version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) that was conducted online within fourteen (14) calendar days from the date of enrollment into the PACE organization.	Clarification.

CHAPTER	SECTION	CHANGE	COMMENT
Program of All-Inclusive Care for the Elderly	3.2 Completion of the Medicaid Nursing Facility LOC Determination	In the 1st paragraph, the 1st sentence was revised to read: A PACE applicant's eligibility for coverage of nursing facility services and enrollment in the PACE organization is determined by the online application of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD). The PACE organization will not be reimbursed for nursing facility services rendered when the applicant is determined not to meet the LOCD criteria. Providers must submit the LOCD information into its online version no later than fourteen (14) calendar days following the start of services. The 2nd paragraph was deleted. In the 3rd paragraph, the 1st sentence was revised to read: The LOCD must be completed by ... In the 4th paragraph, a 3rd bullet point was added: ▪ significant change in condition of a current PACE Medicaid-eligible beneficiary The 5th, 6th, and 7th paragraphs were deleted. The 8th paragraph was revised to read: The online LOCD must be completed only once for each admission or readmission to the program.	Clarification. Removal of obsolete information.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Program of All-Inclusive Care for the Elderly	3.3 Informed Choice	The 1st paragraph was revised to read: When a beneficiary is determined eligible for nursing facility level of care through completion of the online LOCD, he must be provided timely and accurate information to support informed choice for all appropriate Medicaid options for long term care.	Clarification.
Program of All-Inclusive Care for the Elderly	3.4 Nursing Facility LOC Determination Exception Process	Subsection was re-named "Nursing Facility Level of Care Exception Process - Exception Review". Text was revised to read: A Nursing Facility (NF) Level of Care (LOC) Exception Process is a review that is available for financially eligible beneficiaries who have demonstrated a significant level of long term care need but do not meet the LOCD. The NF LOC Exception Process is initiated when the PACE organization telephones the MDCH designee and requests the NF LOC Exception Review on the date that the applicant was determined ineligible based on the online version of the LOCD. The NF LOC Exception criteria and information on how to request an Exception Review is available on the MDCH website. (Refer to the Directory Appendix for website information.)	Clarification.

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

CHAPTER	SECTION	CHANGE	COMMENT
Program of All-Inclusive Care for the Elderly	3.6 Annual Recertification	Text was revised to read: MDCH must annually certify that PACE participants continue to meet PACE financial eligibility requirements. PACE organizations must also ensure that participants continue to meet the LOCD criteria on an ongoing basis. If the participant continues to meet the LOCD criteria, it must be demonstrated in the medical record by way of initial comprehensive assessments, reassessments and progress notes. Additional online LOCDs are not conducted for the purpose of determining ongoing LOCD eligibility. If the PACE participant no longer meets the LOCD criteria, federal regulations may deem the participant to be eligible for the PACE program until the next annual reevaluation if, in the absence of continued coverage under PACE, the participant reasonably would be expected to again meet the nursing facility level of care criteria within the next six months.	Clarification.

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

CHAPTER	SECTION	CHANGE	COMMENT
Program of All-Inclusive Care for the Elderly	3.9 Immediate Review-Adverse Action Notices	Subsection was renamed "Nursing Facility Level of Care Process - Immediate Review Upon Issuance of an Adverse Action Notice". Text was revised to read: The MDCH designee may conduct a Nursing Facility (NF) Level of Care (LOC) Process Immediate Review for a Medicaid pending/eligible beneficiary who was determined functionally/medically ineligible based on the online Michigan Medicaid Nursing Facility Level of Care Determination. The beneficiary, or their representative, must request an Immediate Review before noon of the first working day after the date of receipt of the notice as follows: ▪ The MDCH designee will request the PACE organization to provide medical documentation by close of business of the first business day after the date the beneficiary requests an Immediate Review. ▪ The MDCH designee will review the medical documentation, obtain information from the beneficiary and/or their representative, and notify the beneficiary and the provider of the determination within three business days of receipt of the medical documentation. The beneficiary (or representative) may still request an MDCH appeal of the Michigan Medicaid Nursing Facility Level of Care Determination. (Refer to the Directory Appendix for contact information.)	Clarification.
Program of All-Inclusive Care for the Elderly	3.10 Freedom of Choice	In the 1st paragraph, the 1st sentence was revised to read: When an applicant has been determined eligible for nursing facility level of care through completion of the online LOCD, the beneficiary must be informed of his benefit options and elect to receive services in a specific program.	Clarification.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	6.1.D. Cost Reconciliation and Settlement	In the 5th paragraph, the following sentence was deleted: The initial settlement process will begin in January.	To mirror state plan- RSV 8-29-11
Special Programs	4.1.A. Eligible Beneficiaries	The following text was added after the 2nd sentence: Applicants must also meet the Michigan Medicaid Nursing Facility Level of Care Determination criteria.	Clarification.
Special Programs	4.2 Program of All-Inclusive Care for the Elderly (PACE)	The 1st sentence was revised to read: PACE is a comprehensive service delivery system for frail, elderly individuals who meet the Michigan Medicaid Nursing Facility Level of Care criteria.	Clarification.
Acronym Appendix		Addition of: **LOCD** (Michigan Medicaid Nursing Facility) Level of Care Determination	
Directory Appendix	Eligibility Verification	The following information line was added after "CHAMPS Eligibility Inquiry": Contact/Topic: CHAMPS 270/271 Batch Transaction Email Address: AutomatedBilling@michigan.gov Web Address: www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Electronic Billing >> HIPAA - Companion Guides Information Available/Purpose: A HIPAA 270/271 Batch option is available in CHAMPS for providers and/or their contracted clearinghouse vendors to verify eligibility. HIPAA 270/271 Batch files can be uploaded/retrieved directly into CHAMPS and/or through Data Exchange Gateway (DEG). Refer to the HIPAA 5010 270/271 Inquiry Response Companion Guide for more information.	5010 update.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Nursing Facility Resources	Information for "Nursing Facility Level of Care Determination" was revised as follows: Contact/Topic: Michigan Medicaid Nursing Facility Level of Care Determination Information Available/Purpose: Information and forms necessary to complete the Michigan Medicaid Nursing Facility Level of Care Determination to determine eligibility for NF level of care.	Clarification.
Glossary Appendix	Acquisition Costs	The definition was revised to read: The manufacturer's invoice price, minus primary discount, plus a percentage over cost, plus actual shipping costs. Acquisition cost does not include handling fees. (For the specific percentage over cost, refer to the MDCH Medical Supplier/DME/Prosthetics and Orthotics Database Instructions posted on the MDCH website.)	
Forms Appendix	MSA-1326	The field "MDCH License Number" was revised to read "LARA BHS License Number".	Due to reorganization of Departments.

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

Medicaid Provider Manual
January 2012 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 11-46	10/31/2011	Nursing Facility Cost Reporting & Reimbursement Appendix	Section 3 - Definitions	"Net Quality Assurance Supplement (Net QAS)" was revised to read: The Quality Assurance Supplement minus the Medicaid share of the assessment, based on non-Medicare nursing facility days. Addition of: "Non-Medicare Nursing Facility Days": Nursing Facility days for which Medicare (Part A [Fee for Service] and Part C [Medicare Advantage]) is not the primary source of reimbursement.
			10.13.A. Eligibility Criteria	In the 4th bullet point, the 1st sub-bullet point was revised to read: ➢ ... must be less than the provider's audited Medicaid variable cost per resident day for the provider's two fiscal cost reporting periods (not rate setting periods) of not less than seven months immediately prior to the first period of rate relief. ... the 2nd sub-bullet point was revised to read: ➢ ... The provider must submit to the Reimbursement and Rate Setting Section (RARSS) a copy of the citation and an approved Plan of Correction outlining the action being taken by the provider to address the deficiencies. A copy of facility staffing levels before and after the survey citation must be provided to RARSS to demonstrate the staffing increase is sustained and is not for short-term training purposes only.

*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 3rd sub-bullet point was revised to read: ➢ ... Significant change is defined as an increase of ten minutes per patient day, as demonstrated by Minimum Data Set (MDS) data, which results in a corresponding increase in direct care staffing equal to or greater than the increase in patient minutes per day. ... ... The analysis must also include a comparison of the previous and current nurse staffing levels required based on actual residential census or actual patient days and other nursing-related costs or requirements likely to increase the operational costs. ...
			10.13.H.1. Rate Relief Methodology	In the 2nd paragraph, the 1st sentence was revised to read: Example: The provider's cost report for the period ending December 31, 2010 could be used to set the October 1, 2010 rate if approved for rate relief under the criteria established in the Eligibility Criteria Section of this Appendix. In the 3rd paragraph, the following text was added: This example is applicable to the third and fourth criteria for rate relief qualifications as stated in the Eligibility Criteria Section of this Appendix. The 4th paragraph was revised to read: Example: A cost report time period ending after January 1, 2010 could not be used for accelerated rebasing of a rate effective during the State rate year October 1, 2009 through September 30, 2010.

*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
MSA 11-45	10/1/2011	Hospice	4.2 Beneficiary Elects to Disenroll	The subsection was re-named "Beneficiary Elects to Disenroll/Revoke Their Hospice Benefit". Text was revised to read: A beneficiary may choose to disenroll from, or revoke their election of, hospice care at any time during an election period. The hospice must obtain written documentation, signed and dated by the beneficiary or their representative, stating they are revoking the hospice benefit for the remainder of that election period. The disenrollment or revocation is effective with the date of the beneficiary's/representative's signature. The hospice must give a copy of the disenrollment notice to the beneficiary when they sign it and retain another copy in the beneficiary's record.
			4.3 Hospice Revocation, Disenrollment, or Discharge When Beneficiary is Hospitalized (new subsection; following subsections re-numbered)	New subsection text reads: A beneficiary should **not** revoke, disenroll, or be discharged from hospice for the purpose of admission to the hospital for care related to the hospice diagnosis. Medicaid does not reimburse the hospital separately unless the hospitalization is **not** related to the terminal illness. When this is the case, the hospice may continue to provide care to the beneficiary under the routine hospice care benefit.

*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
			Section 5 - Medicare Conditions of Participation 5.1 Hospice Election Periods (new section; following sections and subsections re-numbered)	New subsection text reads: The duration of hospice coverage is measured in election periods, also known as benefit periods. A beneficiary may elect to receive hospice care during one or more of the following election periods: ▪ An initial 90-day period; ▪ A subsequent 90-day period; or ▪ An unlimited number of subsequent 60-day periods.
			5.2 Certification of the Terminal Illness	New subsection text reads: A hospice must obtain written certification of the terminal illness for each election period before a claim for services is submitted. If the hospice is unable to obtain a written certification within three days of initiation of hospice care, a verbal certification must be obtained, documented, and signed by the person receiving the certification. Statements covering a beneficiary's initial certification must be obtained from the hospice medical director or the physician member of the Interdisciplinary Group (IDG), and the beneficiary's attending physician if the beneficiary has an attending physician. The hospice medical director or the physician member of the IDG certifies the terminal illness for all subsequent election periods.

*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
				Each written certification must include: ▪ A statement that the beneficiary's life expectancy is six months or less if the terminal illness runs its normal course; ▪ Specific clinical findings and other documentation as needed to support the life expectancy of six months or less; ▪ A brief narrative summary; ▪ An explanation why the clinical findings of the face-to-face encounter support a life expectancy of six months or less (beginning with the third benefit period and thereafter); and ▪ Physician signature(s), date signed, and specific election period dates covered by the certification or recertification. Documentation of all written/verbal certifications must be prepared no more than 15 calendar days prior to the effective date of election and must be kept in the beneficiary's medical record.
			5.3 Narrative Summary	New subsection text reads: Each hospice certification and recertification must be accompanied by a brief narrative describing the clinical findings supporting the beneficiary's life expectancy of six months or less. Each narrative must reflect the clinical circumstances and should not contain checkboxes or non-specific, standard language.

*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
			5.4 Face-to-Face Encounter	New subsection text reads: A hospice physician or hospice nurse practitioner (NP) must have a face-to-face encounter with every hospice beneficiary prior to the 180th day of recertification of the beneficiary's terminal illness for the purpose of determining continued eligibility. The 180th day recertification is defined as the recertification that occurs at the start of the third benefit (election) period or the benefit period following the second 90-day benefit period. Additionally, a face-to-face must be conducted at each subsequent recertification (every 60 days thereafter) for as long as the beneficiary is in hospice. Face-to-face encounters must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to each subsequent benefit period thereafter. The hospice physician or NP must attest in writing to the face-to-face encounter with the beneficiary and include the date of the visit. A NP is allowed to perform and attest to the face-to-face encounter; however, the hospice physician must certify and recertify the terminal illness. Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the recertification of the terminal illness requirement. This results in the beneficiary no longer being eligible for the hospice benefit. If this should happen, the hospice must complete a Hospice Membership Notice (form DCH-1074), with the last date of the benefit period as the effective disenrollment date. A comment in the Remarks section of the form is required to explain the reason for the disenrollment.

*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
				There may be an occasional case when a hospice admits a beneficiary who received services from another hospice provider, and the beneficiary chose to revoke or was discharged from that provider. When this occurs, the admitting hospice may begin their care with the beneficiary's first benefit period unless the beneficiary is a direct transfer from the other hospice. When this is the case, the beneficiary's benefit period remains the same, and the transferring hospice should provide the receiving hospice with all required documentation. A hospice resuming care for a beneficiary formerly served by their hospice must restart care in the next or subsequent benefit period.
			6.6 Categories of Care (previously numbered 5.6)	Text for "General Inpatient Care" was revised to read: General inpatient care is covered when the beneficiary's condition is such that their symptoms cannot be adequately treated under the routine hospice care benefit. It is defined as short-term inpatient care provided in a hospice inpatient unit, hospital, or nursing facility meeting hospice standards for staffing and patient areas. This brief episode of care is usually for pain control, or acute or chronic symptom management, that cannot be reasonably treated in another setting. General inpatient care is not to be used solely if a beneficiary requires care in a facility setting. Michigan Medicaid provides payment for room and board in a nursing facility or licensed hospice residence if the beneficiary's hospice care would be more appropriately provided in one of these settings under the routine hospice benefit.

*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
MSA 11-40	9/1/2011	throughout the Manual		Staff/position titles were revised as follows: ▪ references to a therapist and/or assistant being "certified" or "registered" were revised to read "licensed" ▪ "CPTA" to read "PTA" ▪ "COTA" to read "OTA" ▪ "OTR" to read "OT"
		Acronym Appendix		Removal of "COTA".
		Forms Appendix	MSA-1656	Revised to reflect changes noted above.
MSA 11-37	10/1/2011	Beneficiary Eligibility	9.1 Enrollment	In the chart … under "Voluntary Enrollment", the following bullet point was added: ▪ Most people who are dually Medicare/Medicaid eligible under "Excluded Enrollment", the 3rd bullet point was revised to read: ▪ People who are dually Medicare/Medicaid eligible with program codes C, L, N or Q. and the 11th bullet point was revised to read: ▪ People with commercial health plan coverage. This includes beneficiaries enrolled in a Medicare health plan which is not approved to provide Medicaid service in their county.

*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
MSA 11-36	9/1/2011	throughout the Manual		Text relative to billing format/version "4010A1" was revised to read "5010". Text referencing "277U" or "277 Unsolicited" was removed.
		Billing & Reimbursement for Dental Providers	1.2 Remittance Advice	The subsection was renamed "Claim Payment/Claim Status". Subsection text was revised to read: Once claims have been submitted and processed through CHAMPS, an electronic health care claim payment/advice (ASC X12N 835 5010) is sent to the designated service bureau for providers choosing an electronic RA. The CHAMPS RA is also available to providers online or is sent to providers via paper if requested through the Provider Enrollment Subsystem. (Refer to the Remittance Advice Section of this chapter for additional information about both the electronic and paper RA.) To receive information on suspended claims, a provider-initiated 276 claim status request must be submitted and a 277 claim status response will be returned. Providers have the option to receive information on suspended claims via the CHAMPS claims inquiry screens as well.

*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
			5.2 Loss or Change in Eligibility	The 3rd paragraph was revised to read: For services due to loss or change in eligibility: ▪ Complete or partial dentures, laboratory-processed crowns, and/or root canal therapy must have been started prior to the change in/loss of eligibility and completed within 30 days of the date of the change in/loss of eligibility. ➢ Treatment Start Date and Treatment Completion Date are required within loop 2400 DPT.
			5.4 Diagnosis Reporting (new subsection; following subsection re-numbered)	New subsection text reads: For electronic claims, the appropriate diagnosis code is required to be reported for all oral and maxillofacial surgeries and/or anesthesiology services (Loop 2300 HI).
			5.5 Quantity (new subsection; following subsection re-numbered)	New subsection text reads: For electronic claims, "Quantity" is available for use to report the number of services rendered (Loop 2430 SVD/DVD05). The quantity for dental code D0230 (Intraoral periapical, each additional film) is required for proper claim adjudication.

*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
		Billing & Reimbursement for Institutional Providers	1.2 Remittance Advice	The subsection was renamed "Claim Payment/Claim Status". Subsection text was revised to read: Once claims have been submitted and processed through CHAMPS, an electronic health care claim payment/advice (ASC X12N 835 5010) is sent to the designated service bureau for providers choosing an electronic RA. The CHAMPS RA is also available to providers online or is sent to providers via paper if requested through the Provider Enrollment Subsystem. (Refer to the Remittance Advice Section of this chapter for additional information about both the electronic and paper RA.) To receive information on suspended claims, a provider-initiated 276 claim status request must be submitted and a 277 claim status response will be returned. Providers have the option to receive information on suspended claims via the CHAMPS claims inquiry screens as well.

*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
		Billing & Reimbursement for Professionals	1.2 Remittance Advice	The subsection was renamed "Claim Payment/Claim Status". Subsection text was revised to read: Once claims have been submitted and processed through CHAMPS, an electronic health care claim payment/advice (ASC X12N 835 5010) is sent to the designated service bureau for providers choosing an electronic RA. The CHAMPS RA is also available to providers online or is sent to providers via paper if requested through the Provider Enrollment Subsystem. (Refer to the Remittance Advice Section of this chapter for additional information about both the electronic and paper RA.) To receive information on suspended claims, a provider-initiated 276 claim status request must be submitted and a 277 claim status response will be returned. Providers have the option to receive information on suspended claims via the CHAMPS claims inquiry screens as well.
			6.4 Ancillary Medical Services	Under "National Drug Code (NDC) Reporting for Physician Administered Drugs", information for "Electronic Claims" was revised to read: Providers must report the NDC supplemental information in the appropriate segments in the electronic format. Zero dollars (0.00) may also be reported as the NDC Unit Price. A provider who bills a procedure code with multiple NDCs (e.g., compound drug) must repeat the same HCPCS code on multiple service lines allowing each NDC to be reported. The prescription number must be listed on each service line (REF segment) to link this service as one compound drug.

*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
				(Refer to the Directory Appendix for additional resources and website information.)
MSA 11-35	9/1/2011	Dental	6.1.F.1. Complete Series	The 1st paragraph was revised to read: A full mouth or complete series is a covered benefit only once every five years for beneficiaries age 5 and older.
MSA 11-27	7/1/2011	MI Choice Waiver		Addition of policy chapter for MI Choice Waiver Program.
		Private Duty Nursing	1.3 Prior Authorization	In the 1st paragraph, the 1st sentence was revised to read: PDN services must be authorized by the Program Review Division, the Children's Waiver, or the Habilitation Supports Waiver before services are provided.
		Special Programs	4.1.A. Eligible Beneficiaries	Subsection was deleted and information was re-located to 4.1 MI Choice Waiver (Home and Community-Based Waiver for the Elderly and Disabled).
			4.1.B. Covered Services	Subsection was deleted. (Information is now in the MI Choice Waiver chapter.)
		Directory Appendix		General updates were made applicable to the MI Choice Waiver chapter/program.

*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
		Forms Appendix	MSA-0732	Under "Instructions", 1st paragraph, the 2nd sentence was revised to read: This form is to be used for persons with CSHCS or Medicaid coverage, except those beneficiaries enrolled in or receiving case management services from the Children's Waiver or the Habilitation Supports Waiver.
MSA 11-25	6/16/2011	Billing & Reimbursement for Professionals	6.10 Family Planning Clinics (new subsection; following subsections re-numbered)	New subsection text reads: A Family Planning Clinic enrolled with a single billing NPI (representing both the Family Planning Clinic and any other enrolled provider specialty) 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 11-23	6/1/2011	Practitioner Reimbursement Appendix	Section 2- Enhanced Practitioner Payments	The 1st paragraph was revised to read: ... through the following five public entities: and an addition to the bullet list: ▪ Oakland University

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

Michigan Department of Community Health

Supplemental Bulletin List

October - December 2011

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. NOTE: As stated in MSA Bulletin 09-60 issued December 1, 2009, this list includes only those bulletins which have not been formally incorporated into the Medicaid Provider Manual maintained on the MDCH website. The updated list showing all bulletins for the current calendar year 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
12/1/2011	MSA 11-54	Outpatient Prospective Payment System and Ambulatory Surgical Center Reduction Factor	Medicaid, Adult Benefits Waiver, Children's Special Health Care Services, Maternity Outpatient Medical Services (MOMS)	
12/1/2011	MSA 11-52	DRG Grouper Update DRG Rate Update Per Diem Rate Rebasing	Medicaid, Children's Special Health Care Services (CSHCS)	
12/1/2011	MSA 11-50	Changes in Reimbursement for Injectables – J Code Updates	Medicaid, Children's Special Health Care Services (CSHCS), Maternity Outpatient Medical Services Program (MOMS)	
12/1/2011	MSA 11-49	Medicaid Vision Services	Medicaid, Children's Special Health Care Services (CSHCS), and Medicaid Health Plans	
12/1/2011	MSA 11-48	Bridges Eligibility Manual (BEM) Manual Holders	All Medicaid programs	

Michigan Department of Community Health

Supplemental Bulletin List

October - December 2011

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	COMMENTS
12/1/2011	MSA 11-47	Updates to the Medicaid Provider Manual; MDCH Website and Provider Databases/Fee Screens; 5010 Update; Voluntary Enrollment of Dual Eligibles Into Medicaid Health Plans	All Providers	Updates to the Medicaid Provider Manual were incorporated into the Medicaid Provider Manual for the January 2012 update. Remaining subjects are for informational purposes only and will not be incorporated into the Medicaid Provider Manual.
10/1/2011	MSA 11-44	Home Help Policy for the Adult Services Program	Home Help Agencies and Individual Providers	Bulletin will be incorporated into the Department of Human Services (DHS) Adult Services Manual.
9/1/2011	MSA 11-41	***Healthy Kids Dental*** Contract Expansion	Dentists and Dental Clinics	Implementation delayed.
8/01/2009	MSA 09-43	Special Payments to County Medical Care Facilities	County Medical Care Facilities	Pending CMS approval.