MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 12-21

Distribution: All Providers

Issued: June 1, 2012

Subject: Updates to the Medicaid Provider Manual; ICD-10 Coding Implementation

Effective: July 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 July 2012 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.

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.

ICD-10 Coding Implementation

The Centers for Medicare & Medicaid Services (CMS) has announced a proposed one-year delay to extend the deadline for ICD-10 implementation to October 1, 2014. MDCH is moving forward with October 1, 2014 as our "go live" date until CMS announces the final implementation date. It is vital that providers begin transitioning their practice in order to implement the ICD-10 code sets on all HIPAA transactions.

ICD-10-CM codes must be used on all HIPAA transactions, including outpatient claims based on dates of service and inpatient claims based on dates of discharge, on and after October 1, 2014. ICD-10-PCS procedure codes must be used for inpatient services.

As implementation activities progress, MDCH will provide assistance and meaningful resources to ensure implementation by the compliance date.

Any questions regarding ICD-10 implementation should be directed to MDCH-ICD-10@michigan.gov. Additional information is available on the MDCH website at www.michigan.gov/5010icd10. Providers should check the website frequently for ICD-10 updates.

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

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		References to "Clinical Laboratory Improvement Act" were revised to read "Clinical Laboratory Improvement Amendments."	Correction.
Throughout the Manual		References to "Federal Drug Administration" were revised to read "Food and Drug Administration."	Correction.
General Information for Providers	7.3 Out of State/Beyond Borderland Providers	In the 5th paragraph, the 1st sentence was revised to read: … may submit their claims directly to CHAMPS.	Consistency with wording/terminology.
General Information for Providers	9.1 Prior Authorization Certification Evaluation Review (PACER)	In the 8th paragraph, the following text was added: Services during inpatient stays or parts of stays where that stay has been denied as inappropriate or unnecessary may not be resubmitted to MDCH as outpatient charges. Charges resubmitted as outpatient charges are monitored, and any payment made may be recovered during a post-payment audit.	Clarification.
General Information for Providers	9.1.A. Admissions/ Readmissions/Transfers That Require a PACER Number	The 2nd bullet point was revised to read: • All readmissions within 15 days of discharge (including newborns). [NOTE: If a beneficiary is readmitted to the same hospital within 15 days for a related (required as a consequence of the original admission) condition, Medicaid considers the admission and the readmission as one episode for payment purposes. No PACER number is issued for continuation of care.] The 3rd bullet point was revised to read: • All transfers for medical/surgical services to and from any hospital enrolled in the Medicaid program (including newborns). A textbox was added after the 5th bullet point and reads: NOTE: If a newborn does not yet have a Medicaid ID number and a transfer or readmission occurs within 15 days, providers must request a retroactive PACER number when a newborn Medicaid ID number is issued.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	9.1.B. Admissions/ Readmissions/Transfers That Do Not Require a PACER Number	The following text was added to the 1st bullet point: (All transfers and 15-day readmissions to the same or a different hospital **do** require PACER through the ACRC.) The following text was added to the 8th bullet point: (When Medicaid eligibility is determined retroactively, "Retroactive Eligibility" must be entered in the Remarks section of the inpatient hospital claim.)	Clarification.
General Information for Providers	12.3 Billing Limitation	In the 8th paragraph, the 2nd bullet point was revised to read: • Providers can determine if an MSA-1038 has been approved/denied by accessing the MSA-1038 status tool or by contacting the DHS Caseworker. (Refer to the Directory Appendix, Eligibility Verification, for contact and website information.)	Update.
Beneficiary Eligibility	2.1 Benefit Plans	Text in the table was revised as follows (identified by Benefit Plan ID): **ABW - Funding Source** - to read "XIX" **ABW-ESO - Benefit Plan Description** - Text after the 1st sentence was relocated to read as a bullet point. (Bullet point will address multiple Benefit Plans.) **ALMB - Benefit Plan Description** - Text added: "It pays the Medicare Part B premium." **HK-EXP-ESO - Benefit Plan Description** - Text after the 3rd sentence was relocated to read as a bullet point. (Bullet point will address multiple Benefit Plans.) **INCAR-ESO - Type** - to read "No Benefits" **INCAR-MA-E - Type** - to read "No Benefits" **MA-ESO - Benefit Plan Description** - Text after the 1st sentence was relocated to read as a bullet point. (Bullet point will address multiple Benefit Plans.) **MOMS - Benefit Plan Description** - Last sentence to read "... for up to the entire pregnancy and for two calendar months after the pregnancy ends."	Updates.

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CHAPTER	SECTION	CHANGE	COMMENT
		Spend-down - Benefit Plan Description - The 1st sentence is revised to read "If the individual's net income is ...". **TMA-PLUS-E - Benefit Plan Description** - Text after the 3rd sentence was relocated to read as a bullet point. (Bullet point will address multiple Benefit Plans.)	
Beneficiary Eligibility	2.3 Level of Care Codes	In the 3rd paragraph, text was added to the table for Level of Care Codes as follows: for Level of Care Code 13 - **NOTE:** For Dates of Service after 4/30/2012, Level of Care Code 13 is no longer used. for Level of Care Code 14 - **NOTE:** For Dates of Service after 4/30/2012, Level of Care Code 14 is no longer used.	As of 5/1/2012, LOC Code 13 and LOC Code 14 are no longer used.
Beneficiary Eligibility	2.3 Level of Care Codes	In the 3rd paragraph, information in the table was revised as follows: **LOC Code 88 Description** - to read "Used for administrative purposes to indicate beneficiary meets one of the criteria for exemption from mandatory managed care enrollment. The beneficiary should be treated as if the LOC code was blank."	Updated description.
Beneficiary Eligibility	2.6 Special Programs – Beneficiary Identification	The two lines for "BMP" were combined, with information to read: **Benefit Plan ID:** BMP **Program/Eligibility Type:** Beneficiary Monitoring Program	The BMP BP includes pharmacy and provider restrictions.
Beneficiary Eligibility	Section 7 – Newborn Child Eligibility	Text was added at the end of the 1st paragraph and reads: (Refer to the General Information for Providers Chapter of this manual for PACER requirements for newborns.)	Information.
Beneficiary Eligibility	Section 8 - Beneficiary Monitoring Program	The 2nd paragraph was revised to read: A beneficiary who is subject to BMP restriction will be identified with the Benefit Plan ID of BMP. **NOTE:** Prior to 5/1/2012, LOC code 13 (Pharmaceutical Lock-In) or LOC code 14 (Restricted Primary Provider Control) were indicated on the CHAMPS Eligibility Inquiry response as additional information. To obtain provider lock-in information for Dates of Service on 5/1/2012 and after, refer to the BMP Provider Restriction Indicator. If the indicator is "Y", the hyperlink will be activated. The hyperlink will open the BMP Restriction Page which contains the BMP authorized provider information.	Update. LOC 13 and LOC 14 codes will no longer be used as of 5/1/12. Providers will use the BMP Provider Restriction Indicator.

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Coordination of Benefits	2.1 Commercial Health Insurance	In the 4th paragraph, the last sentence was revised to read: For inpatient hospital claims, refer to the Hospital Claim Completion - Inpatient section (Medicare subsection) of the Billing & Reimbursement for Institutional Providers chapter for additional information.	Update.
Coordination of Benefits	2.6.F. Medicaid Liability	In the 4th paragraph, the 4th bullet point was re-formatted as a separate paragraph and was revised to read: For inpatient hospital claims, refer to the Hospital Claim Completion - Inpatient section (Medicare subsection) of the Billing & Reimbursement for Institutional Providers chapter for additional information.	Update
Billing & Reimbursement for Dental Providers	1.3 Additional Resource Material	In the table, under Medicaid Provider Manual, the 2nd sentence was revised to read: A CD copy of the Manual is available at no cost from MDCH.	Update.
Billing & Reimbursement for Institutional Providers	1.3 Additional Resource Material	In the table, under Medicaid Provider Manual, the 2nd sentence was revised to read: A CD copy of the Manual is available at no cost from MDCH.	Update.
Billing & Reimbursement for Institutional Providers	6.2.I. Newborn Eligibility	The following text was added after the 7th sentence: Refer to the General Information for Providers Chapter of this manual for PACER requirements for newborns. The last sentence of the paragraph was removed ("If the newborn does not yet have a Medicaid ID number and a readmission occurs within 15 days, providers must request a retroactive PACER number when a newborn Medicaid ID number is issued.").	Clarification.
Billing & Reimbursement for Institutional Providers	6.2.J. Patient-Pay Amount	The 5th bullet point was revised to read: • When an admission spans two or more months, the facility must collect the patient-pay amount for each month the beneficiary is in the facility (for Level of Care (LOC) Code 02 and LOC Code 16). A 6th bullet point was added and reads: • When an admission spans two or more months, the facility only collects one spend-down amount for the entire hospital admission (for LOC Code 10).	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	8.3 Hospital Leave Days	The text box at the end of the subsection was removed.	Obsolete information.
Billing & Reimbursement for Institutional Providers	8.9 Cost Settled Provider Detail Report (FD-622)	Subsection text was revised in its entirety to read: A Cost Settled Provider Detail Report (FD-622) is available to nursing facilities (nursing homes, county medical care facilities, hospital long-term care units, ventilator-dependent care units, and hospital swing beds). The FD-622 provides detailed information of a facility's charges paid by Medicaid. Since MDCH acts as a fiscal agent for many different sources of payment, the FD-622 includes all of these sources. This report can be used in conjunction with the Remittance Advice (RA) to reconcile the accounts receivable and used as the actual log that the facility must maintain for Medicaid, eliminating duplication of paperwork by the facility. The FD-622 includes: • Medicaid payroll information, • the facility's billing information, • the facility's current interim reimbursement rate, • an indicator if the facility is on Medicaid Interim Payments, • beneficiary information on services billed to Medicaid, • summary of cost settled services, • total charges billed to Medicaid, • amount paid by Medicare, other insurance, beneficiary, • Medicaid payments, • gross adjustments, and • Medicaid claim statistic information. The detail portion of the FD-622 report is available in both paper and electronic versions. Additional information is available on the MDCH website. (Refer to the Directory Appendix, Nursing Facility Resources, for website information.)	Reference to an electronic version of the FD-622 was relayed to nursing facilities via March 19, 2012 letters from MDCH, Medical Services Administration, Bureau of Medicaid Financial Management, LTC Reimbursement and Rate Setting Section.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	10.1 Direct Billing to MDCH	The following was added as a 2nd paragraph for **Multiple Beneficiaries Seen at Same Location**: When billing for services for one child (when two have been authorized), do not use the TT modifier along with the HCPCS code. Claims will not pay for one child unless the following comment is entered in the Remarks section of the claim: "Only one child present at time of service, documentation on file."	Clarification.
Billing & Reimbursement for Institutional Providers	11.1 Billing Instructions for Hospice Claim Completion	The 3rd bullet point was revised to read: • ... include value code 61 in the value code field and report the CBSA number followed by two zeros. Hospice claims must be reported with a valid CBSA code based on the location of the beneficiary receiving services. In the 5th bullet point, the 3rd sentence was revised to read: Room and board is reimbursable on the day of discharge if the discharge is due to resident death or the resident is discharged from hospice but remains in the NF.	Clarification.
Billing & Reimbursement for Professionals	1.3 Additional Resource Material	In the table, under Medicaid Provider Manual, the 2nd sentence was revised to read: A CD copy of the Manual is available at no cost from MDCH.	Update.
Billing & Reimbursement for Professionals	6.17.A. Direct Billing to MDCH	The following was added as a 2nd paragraph for **Multiple Beneficiaries Seen at Same Location**: When billing for services for one child (when two have been authorized), do not use the TT modifier along with the HCPCS code. Claims will not pay for one child unless the following comment is entered in the Remarks section of the claim: "Only one child present at time of service, documentation on file."	Clarification.
Children's Special Health Care Services	Section 3 - Medical Eligibility	In the 1st paragraph, the 1st sentence was revised to read: CSHCS covers over 2,700 medical diagnoses …	Update.
Children's Special Health Care Services	Section 3 - Medical Eligibility	In the 3rd paragraph, the last sentence was revised to read: … by an appropriate physician subspecialist through the network of the respective health plan or health insurance carrier to provide …	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.3 Restorative Treatment	Subsection text was re-written in its entirety and now reads: Restorative treatment, using Amalgam or Resin-Based Composite materials to restore carious lesions or fractured teeth, is a covered benefit for all beneficiaries. Restorative treatment is limited to those services necessary to restore and maintain adequate dental health. No reimbursement is made for any restorative treatment within two years of placement. Replacement is the treating dentist's responsibility. Restorations are not covered for deciduous teeth where exfoliation is expected to occur within 180 days. Restorations of deciduous molars and cuspids are not covered for ages 12 or older, and restorations of deciduous incisors are not covered for ages 5 or older. Dentists must report procedures using the appropriate dental procedure codes defined in the CDT (Current Dental Terminology) resources. The current definitions of surfaces and the multiple surface codes are to be used as written.	Re-written for clarity. Information regarding core build-up or post and core substructures was relocated to subsection 6.3.C. Crowns.
Dental	6.3.A. Amalgam Restorations	Subsection text was re-written in its entirety and now reads: Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are not separate benefits and must be included in the total fee for the restorations. If pins are used, they should be reported under the appropriate code.	Re-written for clarity.
Dental	6.3.B. Resin-Based Composite Restorations - Direct	Subsection text was re-written in its entirety and now reads: Resin-based composite refers to a broad category of materials including, but not limited to, composite, light-cured composite and glass ionomers. Tooth preparation, acid etching, adhesives, bonding agents, liners, bases and curing are included as part of the restoration. If pins are used, they should be reported under the appropriate code.	Re-written for clarity.
Dental	6.3.C. Crowns	Subsection text was re-written in its entirety and now reads: Limited crown coverage for beneficiaries under age 21 includes: • Stainless steel crown -- for primary teeth and permanent molars. • Stainless steel crown with resin window -- for anterior primary teeth. • Laboratory-processed resin crown (indirect) -- for anterior permanent teeth only; prior authorization (PA) is required.	Re-written for clarity.

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CHAPTER	SECTION	CHANGE	COMMENT
		The following are allowed for permanent teeth only when a restorative crown will be placed: • Direct core build-up, including any pins • Post and core substructures (indirectly fabricated or prefabricated)	
Dental	8.2.A. Orthodontic Services	Subsection text was re-written in its entirety and now reads: Prior authorization requests for orthodontic services must be submitted prior to the initiation of treatment and placement of bands. Requests submitted after treatment has begun may result in the prior authorization being denied. The provider is responsible for verification of eligibility on the date of service. The pre-orthodontic treatment visit, which includes the examination, diagnostic casts, and photos (optional), does not require prior authorization. X-rays (full mouth series, cephalometric and panoramic) are billed separately from the evaluation. All other orthodontic services require prior authorization.	Re-written for clarity.
Hospice	Section 2 - Provider Requirements	In the 3rd paragraph, the 1st sentence was revised to read: MDCH requires Hospice agencies to be licensed in Michigan by the state-licensing agency...	Clarification.
Hospice	Section 4 - Beneficiary Disenrollment	The 1st and 2nd sentences were revised to read: A beneficiary may disenroll or be discharged from hospice as noted below. A DCH-1074 indicating the reason for the disenrollment or discharge must be signed and dated by the beneficiary and/or authorized representative as proof of notification (unless the beneficiary has expired).	Clarification.
Hospice	4.4 Beneficiary No Longer Meets Enrollment Criteria	The 2nd sentence was revised to read: If the beneficiary is discharged for this reason, ...	Clarification.
Hospice	4.7 Hospice Elects to Terminate the Beneficiary's Enrollment	The 1st paragraph was revised to read: The hospice may discharge a beneficiary if the beneficiary violates any of the conditions of membership in the hospice. The decision to discharge a beneficiary and the effective date of the discharge are determined on an individual basis by the hospice Medical Director.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospice	6.2 Other Hospice Covered Services	The 2nd bullet point was revised to read: • Medical Supplies/Durable Medical Equipment (DME)	Clarification. Note: The list was placed in alphabetical order for ease in locating material.
Hospice	6.6 Categories of Care	Under "General Inpatient Care", the 2nd sentence was revised to read: It is defined as short-term inpatient care provided in a licensed hospice NF, hospital, or NF meeting hospice standards for staffing and patient areas. and the 5th sentence was revised to read: Michigan Medicaid provides payment for room and board in a nursing facility or licensed hospice NF with "licensed only" nursing home beds if the beneficiary's hospice care…	Clarification.
Hospice	7.3.C. Date of Discharge	In the 2nd paragraph, the 1st sentence was revised to read: Room and board for a hospice/nursing facility (NF) resident is reimbursable on the day of discharge if the discharge is due to resident death or the resident is discharged from hospice but remains in the NF.	Clarification.
Local Health Departments	2.2.A. Initial Blood Lead Testing	In the 1st paragraph, the 1st sentence was revised to read: … obtain a referral or receive PA to obtain a blood lead sample from Medicaid-covered children through six years of age, whether they are …	Changing "up to six years of age" to "through six years of age" to match CHAMPS and database.
Local Health Departments	2.3 Additional Information on Objective Hearing & Vision Screening	In the 2nd paragraph, the 1st sentence was revised to read: … performed on eligible Medicaid preschool-aged children from age three through six years of age by qualified LHD staff.	Clarifying coverage is "through 6 years of age", not "to the age of 6."
Local Health Departments	2.5 Medicaid Health Plan Services	In the 1st paragraph, the 5th bullet point was revised to read: • Blood lead draws for children through six years of age	Changing "up to six years of age" to "through six years of age" to match CHAMPS and database.
Maternal Infant Health Program	1.2 Staff Credentials	Under Social Workers, the last bullet point was revised to read: • at least one year of experience providing Social Work services to families.	Clarification and consistency.

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CHAPTER	SECTION	CHANGE	COMMENT
Medical Supplier	1.5 Medical Necessity	The 3rd paragraph was revised to read: Medical equipment may be determined to be medically necessary when all of the following apply: • The service/device meets applicable federal and state laws, rules, regulations, and MDCH promulgated policies. • It is medically appropriate and necessary to treat a specific medical diagnosis, medical condition, or functional need, and is an integral part of the nursing facility daily plan of care or is required for the community residential setting. • The function of the service/device: ➢ meets accepted medical standards; ➢ practices guidelines related to type, frequency, and duration of treatment; and ➢ is within scope of current medical practice. • It is inappropriate to use a nonmedical item. • It is the most cost effective treatment available. • The service/device is ordered by the treating physician, and clinical documentation from the medical record supports the medical necessity for the request (as described above) and substantiates the physician's order. • The service/device meets the standards of coverage published by MDCH. • It meets the definition of Durable Medical Equipment (DME), as defined in the Program Overview section of this chapter. • Its use meets FDA and manufacturer indications.	Clarification.
Medical Supplier	1.8.C. Repairs and Replacement Parts	The 10th paragraph was revised to read: The provider may not provide or substitute a service of lesser quality or provide a different brand or type than what was authorized through prior authorization.	Clarification.
Medical Supplier	1.9.B. HCPCS Modifiers - Left and Right Side of the Body	The 2nd paragraph was revised to read: The provider may not provide or substitute a service of lesser quality or provide a different brand or type than what was authorized through prior authorization.	Clarification.
Medical Supplier	2.3 Blood Glucose Monitoring Equipment and Supplies	Under Documentation, the 3rd bullet point was revised to read: • Quantity of items to be dispensed for 30 days usage.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Medical Supplier	2.18 Hospital Beds	Under PA Requirements, in the 2nd paragraph, the 3rd bullet point was revised to read: • Replacement of a fixed height, variable height, or semi-electric bed and/or accessory within five years.	Clarification.
Medical Supplier	2.39 Speech Generating Devices	Under Documentation, in the 4th paragraph, the 2nd bullet point was revised to read: • Clinical confirmation by a speech-language pathologist and occupational or physical therapist of the beneficiary's functional ability to use the SGD.	Clarification.
Medical Supplier	2.40 Support Surfaces - Group 1	Under PA Requirements, the 11th bullet point was revised to read: • Hemiplegia and Hemiparesis and the 12th bullet point was deleted.	Spelling correction; removal of obsolete information.
Nursing Facility Coverages	5.1.D.6. Adverse Action Notice	In the 4th paragraph, the 3rd bullet point was revised to read: • … or their representative may request an MDCH hearing based on a LOCD denial.	Correction.
Outpatient Therapy	1.1 Service Provision	The 1st sentence was revised to read: Outpatient therapy may be provided by Medicaid-enrolled providers …	Removal of obsolete wording.
Outpatient Therapy	1.2 Outpatient Therapy Database	The 3rd sentence was revised to read: The database includes all covered outpatient therapy codes and applicable frequency limits.	Removal of obsolete wording.
Practitioner	3.4.A. Hearing	Under Preschool, in the 2nd paragraph, the 1st sentence was revised to read: Objective hearing screening may be performed on eligible Medicaid preschool-aged children from age three through six years of age by qualified LHD staff.	Clarifying coverage is "through 6 years of age", not "to the age of 6."
Practitioner	3.4.B. Vision	Under Preschool, the 3rd sentence was revised to read: Objective vision screening may be performed on eligible Medicaid preschool-aged children from age three through six years of age by qualified LHD staff.	Clarifying coverage is "through 6 years of age", not "to the age of 6."

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CHAPTER	SECTION	CHANGE	COMMENT
Private Duty Nursing	1.4.A. Documentation Requirements	The 1st bullet point was revised to read: • Most recent signed and dated nursing assessment, including a summary of the beneficiary's current status compared to their status during the previous authorization period, completed by a registered nurse. The 3rd bullet point was revised to read: • Most recent updated plan of care (POC) signed and dated by the ordering/managing physician, RN, and the beneficiary's parent/guardian. The POC must support the skilled nursing services requested; The 4th sub-bullet point was revised to read: ➢ Frequency and duration of skilled nursing visits ... The 8th sub-bullet point was relocated/re-formatted to read as the 4th bullet point.	Clarification and consistency.
Private Duty Nursing	1.13 Caring for More Than One Patient at a Time	The following text was added as a 2nd paragraph: A PDN authorized to provide services to two children at the same location may find that, at times, only one child is present to receive services. This may occur when one child is in school, at a medical appointment, hospitalized, or on a family outing. The beneficiary record must document why only one child was present to receive services, as well as the beginning and ending time of the services. (Refer to the appropriate Billing and Reimbursement chapter for billing instructions.)	Clarification.
Private Duty Nursing	2.1 Plan of Care	In the 1st bullet point, the 2nd sentence was revised to read: They are provided with accurate information and support appropriate to informed decision-making. They must give informed consent for the planned services by signing and dating the POC annually and when updating the POC as needed based on the beneficiary's medical needs.	Clarification and consistency.
Private Duty Nursing	2.6 Change in Beneficiary's Condition/PDN as a Transitional Benefit	In the 1st paragraph, the 2nd sentence was revised to read: ... the provider must report the change to the appropriate authorizing agent (i.e., the Program Review Division, Children's Waiver, or Habilitation Supports Waiver) **in writing**.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Program of All-Inclusive Care for the Elderly	3.2 Completion of the Medicaid Nursing Facility LOC Determination	In the 3rd paragraph, the 1st sentence was revised to read: … must be completed using the online version in the following situations:	For consistency in wording.
Acronym Appendix		References to "Family Independence Agency" and "FIA" were removed.	Obsolete information.
Acronym Appendix		NCD was revised to read: National Coverage Determination	Correction.
Directory Appendix	Eligibility Verification	Under "Michigan Public Health Institute (MPHI)", under Information Available/Purpose, the following information was added: • MSA-1038 status tool: Search by Member ID or Name/DOB to determine the status of a submitted MSA-1038. Database is updated on a daily basis.	Update.
Directory Appendix	Prior Authorization (Authorization of Services)	In the first row of this section, Contact/Topic for "MDCH Office of Health Services Inspector General" was changed to read "Program Review Division, Beneficiary Monitoring Program" and "Information Available/Purpose" was revised to read: Inquiries by beneficiaries and providers regarding the Beneficiary Monitoring Program.	Update.
Directory Appendix	Provider Resources	Addition of: **Contact/Topic:** Clinical Laboratory Improvement Amendments (CLIA) **Web Address:** http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/testswaived.cfm **Information Available/Purpose:** List of lab tests waived under CLIA.	Information was re-located from the Nursing Facility Resources section; website address was updated.
Directory Appendix	Nursing Facility Resources	Under "Nursing Facility Forms & Instructions, Calculation Examples, Rate Relief Worksheet", information was added regarding the Cost-Settled Provider Detail Report (FD-622). General updates were made to the website address and to "Information Available/Purpose."	Update.
Directory Appendix	Nursing Facility Resources	"Clinical Laboratory Improvement Amendment (CLIA)" information was removed.	Information was relocated to the Provider Resources section.

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Directory Appendix	School Based Services	Under "SBS Administrative Outreach Program Policy Specialist," the phone number was revised to read: 517-241-8398	Correction.
Forms Appendix	MSA-0732	Addition of "County" field for beneficiary information; following fields were re-numbered; instructions were revised to address changes.	Form field added to address need for additional information.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 12-14	5/1/2012	Chiropractor	Table of Contents	The informational textbox on the Table of Contents page was removed as content is no longer applicable.
MSA 12-13	5/1/2012	Dental	6.1.F. Radiographs	Policy bulletin content was incorporated into this subsection; revisions include re-organization of information resulting in re-numbering and re-titling of subsections.
MSA 12-11	3/30/2012	Mental Health/ Substance Abuse	12.2 Office of Pharmacological and Alternative Therapies/Center for Substance Abuse Treatment (OPAT/CSAT) Approved Pharmacological Supports	Policy bulletin content was incorporated into this subsection as a total re-write of text. Revisions include renaming of the subsection to "Treatment (DPT/CSAT) Approved Pharmacological Supports" and the addition of subsections.
MSA 12-07	3/1/2012	Directory Appendix	Reporting Fraud, Abuse, or Misuse of Services	The phone number for MDCH Office of Health Services Inspector General was revised to read 1-855-MI-FRAUD (643-7283).
MSA 12-05	3/1/2012	Hearing Aid Dealers	2.8 Earmolds for Cochlear Implants	Subsection was deleted; following subsections were re-numbered. (Subsection text was re-located to the Hearing Services Chapter.)
		Hearing Services	2.3 Cochlear Implants and Auditory Osseointegrated Devices 2.4 Cochlear Implant Manufacturers	Policy bulletin content was incorporated into these subsections; revisions include re-organization of information resulting in re-numbering and re-titling of subsections.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			2.5 Replacement of Auditory Osseointegrated Devices 2.6 Reimbursement for Procedure Codes Identified with Not Otherwise Classified (NOC) or $0.01 Screen	
MSA 09-43	8/1/2009	Nursing Facility Cost Reporting and Reimbursement Appendix	Section 10 - Rate Determination	Policy bulletin content was incorporated into this section as a new subsection: 10.14 County Medical Care Facilities Special Payments Program (CMCFSP)
MSA 08-51	10/15/2008	General Information for Providers	6.1 General Information	The following text was added as a 5th paragraph: Any entity that offers, in writing or verbally, discounts on co-pay amounts, fax machines, computers, gift cards, store discounts and other free items, or discounts/waives the cost of medication orders if an entity uses their services: • May violate the Medicaid False Claim Act and Medicaid/MDCH policy, which may result in disenrollment from Medicaid/MDCH programs. • May violate the Michigan Public Health Code's prohibition against unethical business practices by a licensed health professional, which may subject a licensee to investigation and possible disciplinary action.

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Michigan Department of Community Health

Supplemental Bulletin List

April - June 2012

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
6/1/2012	MSA 12-23	Inpatient Hospital Payment Reduction	Hospitals	
6/1/2012	MSA 12-19	Expansion of Hospice Face-to-Face Encounter to Allow Services by a Hospice-Employed Physician Assistant (PA)	Hospice, Practitioners	
6/1/2012	MSA 12-22	Reconciliation of QAS Payments to Nursing Facilities	Nursing Facilities	
6/1/2012	MSA 12-20	Health Insurance Program (HIP) Enrollment	Hospitals, Physicians, Local Health Departments, Medical Clinics	
6/1/2012	MSA 12-18	Wraparound Services	Prepaid Inpatient Health Plans	
6/1/2012	MSA 12-16	Online Oral Health Training for Medical Providers	Physicians, Advanced Practice Nurses, Medical Clinics, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, Local Health Departments, Medicaid Health Plans	

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DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	COMMENTS
5/10/2012	MSA 12-17	Sanctioned Providers Update	All Providers	A complete list of sanctioned providers is available on the Michigan Department of Community Health (MDCH) website at: www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> List of Sanctioned Providers
4/17/2012	MSA 12-12	Sanctioned Providers Update	All Providers	A complete list of sanctioned providers is available on the Michigan Department of Community Health (MDCH) website at: www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> List of Sanctioned Providers
3/30/2012	MSA 12-10	Estate Recovery for Supplemental Security Income Related Medicaid Programs	Bridges Administrative Manual (BAM) Holders	Bulletin content incorporated into Bridges Administrative Manual; not applicable to MDCH Medicaid Provider Manual.
3/30/2012	MSA 12-09	Medicaid Eligibility and Divestment Penalties	Bridges Eligibility Manual (BEM) Holders	Bulletin content incorporated into Bridges Eligibility Manual; not applicable to MDCH Medicaid Provider Manual.
3/15/2012	MSA 12-08	Sanctioned Providers Update	All Providers	A complete list of sanctioned providers is available on the Michigan Department of Community Health (MDCH) website at: www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> List of Sanctioned Providers