MSA Bulletin

MEDICAL SERVICES ADMINISTRATION

Michigan Department of Community Health

Bulletin Number: MSA 13-40

Distribution: All Providers

Issued: August 29, 2013

Subject: Updates to the Medicaid Provider Manual; Beneficiary Monitoring Program; ICD-10 Project Update

Effective: As Indicated

Programs Affected: Medicaid, Adult Benefits Waiver, Children's Special Health Care Services, Children's Waiver, Maternity Outpatient Medical Services, MIChoice Waiver, *Plan First!*

Updates to the Medicaid Provider Manual

The Michigan Department of Community Health (MDCH) has completed the October 2013 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.

Beneficiary Monitoring Program

Effective October 1, 2013, the Beneficiary Monitoring Program (BMP) will change its name to the Benefits Monitoring Program. The Medicaid Provider Manual, related websites, forms, etc. will be modified to reflect the new name. The program functions will not change as a result of this name change.

ICD-10 Project Update

MDCH continues to transition its policies, procedures and information systems to support the ICD-10 code sets on all Health Insurance Portability and Accountability Act (HIPAA) transactions by the federally mandated compliance date of October 1, 2014. Prior to implementing the new ICD-10 processing functions into its systems, MDCH will present Medicaid providers and trading partners with an opportunity to test their ability to communicate with MDCH using ICD-10 coded transactions.

These testing activities are scheduled to begin in October of 2013 and will start with scenario-based testing activities where providers are invited to assign ICD-10 codes to medical scenarios that apply to their practice areas. This will be followed by full-scale Business-to-Business (B2B) testing of ICD-10 coded claims and encounter transactions, including adjudication in the B2B Test environment, starting January 2014. These activities are designed to help providers ensure that their remediation efforts to prepare for the transition to ICD-10 have resulted in the creation of transactions that can be processed successfully.

Any questions regarding ICD-10 implementation should be directed to MDCH-ICD-10@michigan.gov. Providers should continue to frequently check the MDCH website at www.michigan.gov/5010icd10 for ICD-10 updates, including additional details regarding testing opportunities and procedures in upcoming months. Providers are encouraged to check for available ICD-10 trainings on the MDCH website at www.michigan.gov/medicaidproviders >>Hot Topics >> Medicaid Provider Training Sessions.

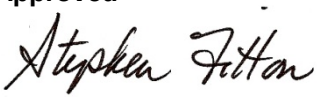
Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

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
October 2013 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		References to "Beneficiary Monitoring Program" were revised to read "Benefits Monitoring Program".	Update.
Throughout the Manual		References to SCHIP and/or State Children's Health Insurance Program were revised to read CHIP and/or Children's Health Insurance Program.	Update.
General Information for Providers	9.4 Contractor Monitoring (new subsection)	Subsection text reads: MDCH monitors ACRC review and case determinations to verify that the ACRC is: • appropriately applying review criteria in compliance with Medicaid policy. • making proper determination of medical necessity and appropriateness of setting. • performing all duties in a manner acceptable to MDCH. Following subsections were re-numbered.	Information was previously located in the Hospital Chapter. Information was inadvertently removed instead of being relocated.
General Information for Providers	9.5 Confidentiality (new subsection)	Subsection text reads: As an agent of the State, the ACRC may access all records related to care provided to Medicaid beneficiaries and is subject to the same state and federal confidentiality requirements as Medicaid staff. The failure of a hospital to make all records available to the contractor results in denial of that case and subjects that hospital to Medicaid participation sanctions. Additionally, the contractor makes allowable disclosures of statistical information after MDCH review and approval. Following subsections were re-numbered.	Information was previously located in the Hospital Chapter. Information was inadvertently removed instead of being relocated.
General Information for Providers	12.3 Billing Limitation	In the 7th paragraph, the 3rd bullet point was revised to read: • Judicial Action/Mandate: A court or MAHS administrative law judge ...	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Revisions to the table after the 2nd paragraph are: **Benefit Plan ID:** ABW Covered Services: addition of 91 and 92 **Benefit Plan ID:** CSHCS Covered Services: addition of 48 and 50 **Benefit Plan ID:** MA Covered Services: addition of 91 and 92 **Benefit Plan ID:** MI Choice Benefit Plan Description: revised to read "This benefit plan allows claims adjudication for hospice services provided to beneficiaries who are eligible for the MI Choice -MC benefit plan. MI Choice Waiver services are provided through the managed care program MI Choice-MC." Covered Services: removal of "42"; addition of "45" **Benefit Plan ID:** MI Choice-MC (addition of new benefit plan) Benefit Plan Name: Home and Community Based Waiver Services Managed Care Benefit Plan Description: The MI Choice Waiver is a managed care program that provides home and community-based services for aged and other disabled adults who meet the nursing facility level of care. The program's goal is to provide long-term services and supports that allow persons to remain at home or similar community-based settings. These persons qualify for nursing facility services but choose to receive services in their home. MI Choice beneficiaries are eligible to receive Medicaid state plan services but are excluded from enrollment in a Medicaid Health Plan. Type: Managed Care Organization Funding Source: XIX Covered Services: 42	Update

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CHAPTER	SECTION	CHANGE	COMMENT
		Benefit Plan ID: MIChild Covered Services: addition of AL **Benefit Plan ID:** MME-MC Covered Services: addition of 98 **Benefit Plan ID:** TMA-PLUS Covered Services: addition of 91 and 92	
Beneficiary Eligibility	Section 7 - Newborn Child Eligibility	The 2nd paragraph was revised to read: If the mother is enrolled in a MHP at the time of delivery, the newborn's services are also the responsibility of the MHP unless the child is placed in foster care.	Clarification.
Beneficiary Eligibility	Section 8 - Beneficiary Monitoring Program	The 2nd paragraph was revised to read: The purpose of the Benefits Monitoring Program is to: • Promote quality health care; • Promote patient safety through reduction of drug interaction and/or possible drug abuse, and duplication of medical services; • Identify beneficiaries whose utilization patterns appear to be overutilization and/or misutilization of their Medicaid benefits; • Analyze individual beneficiary health service utilization data; • Improve beneficiary utilization of Medicaid services through educational contacts and monitoring; • Improve the continuity of care and service coordination to prevent fragmentation of services; • Assure that beneficiaries are receiving health care services which are medically necessary and supported by evidence-based practices, thereby curtailing unnecessary costs to the program.	Clarification.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	8.2.B. Misutilization of Emergency Department Services	The 3rd bullet point was revised to read: • More than one outpatient hospital emergency department facility in one quarter.	Correction
Beneficiary Eligibility	8.2.C. Misutilization of Medical Transportation Services	Subsection was removed. Following subsections were re-numbered.	Due to limitations, transportation services will not be considered for BMP placement.
Beneficiary Eligibility	8.2.E. Misutilization of Physician Services	Bullet points were revised to read: • Utilizing more than one physician/physician extender in different practices to obtain duplicate or similar services for the same or similar health condition. • Utilizing more than one physician/physician extender in different practices to obtain duplicate prescriptions for a drug(s) listed in the Drug Categories subsection of this chapter (e.g., two prescriptions for Vicodin/hydrocodone written by different providers within an overlapping timeframe).	Clarification.
Beneficiary Eligibility	8.7.E. Potential Misutilization	Subsection was renamed: Referrals to BMP	Clarification.
Beneficiary Eligibility	8.7.F. Fraud	Subsection was renamed: Beneficiary Fraud	Clarification.
Beneficiary Eligibility	8.8 Changes in Enrollment	The following text was added: When a beneficiary has a break or change in eligibility that disrupts historical data collection and review, upon regaining full Medicaid eligibility, the beneficiary will, by default, remain in the BMP and periodic review will depend on availability of sufficient utilization data.	Clarification.

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Medicaid Provider Manual
October 2013 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	9.1 Enrollment	In the table, under "Excluded Enrollment", the 10th bullet point was revised to read: • People with commercial managed care coverage. This includes beneficiaries enrolled in a Medicare health plan which is not approved to provide Medicaid service in their county. and the 15th bullet point was revised to read: • People who have been disenrolled from a Medicaid health plan.	Clarification.
Coordination of Benefits	2.1 Commercial Health Insurance, Traditional Indemnity Policies, and Military/Veteran Insurance	In the 6th paragraph, the 1st sentence was revised to read: Providers must secure other insurance adjudication response(s) which must include Claim Adjustment Reason Codes (CARCs) prior to billing Medicaid.	Clarification.
Coordination of Benefits	2.6.F. Medicaid Liability	In the 4th paragraph, the 1st sentence was revised to read: MDCH reimburses providers for the coinsurance and deductible amounts subject to Medicaid reimbursement limitations on all Medicare approved claims even if Medicaid does not normally cover the service. The 2nd bullet point was revised to read: • The Medicaid fee screen/allowable amount, minus any Medicare or other insurance payments and ... The 3rd bullet point was revised to read: • The provider's charge, minus any Medicare or other insurance payments, ...	Revised language will maintain consistency throughout the Manual.
Billing & Reimbursement for Institutional Providers	7.28 Therapies (Occupational, Physical and Speech-Language)	In the table in the 2nd paragraph ... under Occupational Therapy: • the 1st bullet point was revised to read "... within the first 12 consecutive calendar months of therapy. ..."	To correct/update information released in bulletin MSA 12-02.

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CHAPTER	SECTION	CHANGE	COMMENT
		• the 6th bullet point was revised to read "... beyond the initial 12 consecutive calendar months of therapy." under Physical Therapy: • the 1st bullet point was revised to read "... within the first 12 consecutive calendar months of therapy. ..." • the 4th bullet point was revised to read "... beyond the initial 12 consecutive calendar months of therapy." under Speech Therapy: • the 1st bullet point was revised to read "... within the first 12 consecutive calendar months of therapy. ..." • the 5th bullet point was revised to read "... beyond the initial 12 consecutive calendar months of therapy."	
Billing & Reimbursement for Institutional Providers	8.15 Part A Co-Insurance Rate for Nursing Facility Care (new subsection)	New subsection text reads: Medicaid co-insurance payments for Part A are the lower of the co-insurance charge or the current maximum co-insurance rate established under the formula stated in the Social Security Act. The facility's total payments from Medicare, Medicaid and other insurance may be up to, but cannot exceed, the amount established by Medicare as reasonable (i.e., the amount allowed by Medicare). Following subsections were re-numbered.	Restore information inadvertently removed from Manual.
Billing & Reimbursement for Institutional Providers	8.17 Long-Term Care Insurance	Subsection text was revised to read: Federal regulations require that all identifiable financial resources available for payment, including long-term care insurance, be billed prior to billing Medicaid. (Refer to the Coordination of Benefits chapter for additional information.)	Revised language will maintain consistency throughout the Manual.
Billing & Reimbursement for Professionals	2.3.B. Rendering Provider	A second paragraph was added and reads: School-Based Services providers are exempt from this requirement and are not required to provide rendering NPIs on their claims.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Ambulatory Surgical Centers	3.1 Payment Calculation	The 2nd paragraph was revised to read: Refer to the Coordination of Benefits chapter for information regarding MDCH's payment liability.	Revised language will maintain consistency throughout the Manual.
Children's Special Health Care Services	Section 4 - Application Process	The 5th paragraph was revised to read: When a medical report is submitted to CSHCS on behalf of a beneficiary with full Medicaid coverage or MIChild and the CSHCS medical consultant determines that the beneficiary is medically eligible for CSHCS, the beneficiary is automatically enrolled in CSHCS without completing the CSHCS application.	Further clarification on MIChild, indicating client will be automatically enrolled with CSHCS.
Children's Special Health Care Services	9.1 Specialty Dental Benefits	The 1st paragraph was revised to read: Specialty dentistry refers to services that are not covered under the Medicaid dental benefit but are covered for CSHCS enrollees who have a qualifying diagnosis that may include specialty dental services. Services include, but are not limited to, orthodontia and specialty crown and bridge. All CSHCS beneficiaries do not qualify for specialty dental services. Qualification for specialty dental services is based on the specific diagnoses and treatment plan. Examples of CSHCS diagnoses that may qualify for specialty dental services include: • Amelogenesis imperfecta, Dentinogenesis imperfecta • Anodontia which has significant effect on function • Cleft palate • Ectodermal dysplasia, epidermolysis bullosa with significant tooth involvement *(NOTE: remainder of paragraph remains unchanged)*	Clarification.
Dental	2.4 Approved Prior Authorization Requests	The 3rd paragraph was revised to read: PA is granted under the NPI submitted on the PA form. Provided it is the group NPI, it may be transferred or used by any dentist within the same organization without contacting the MDCH Dental Prior Authorization Unit.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.1.B. Comprehensive Oral Evaluation	Text was revised to read: A comprehensive oral evaluation is performed on a new patient or an established patient with significant health changes or absence from treatment for three or more years. The evaluation must include a documented medical and dental history, a thorough evaluation and recording of the condition of extraoral and intraoral hard and soft tissues, including a complete charting of the condition of each tooth and supporting tissues, occlusal relationships, periodontal conditions, including periodontal charting, oral cancer screening and appropriate radiographic studies (radiographs are separately reimbursable).	Clarification.
Dental	6.1.C. Periodic Oral Evaluation	Text was revised to read: A periodic oral evaluation is an examination of a patient of record, to determine any changes in a beneficiary's dental and medical health status since a previous comprehensive or periodic examination. The periodic oral evaluation must include a written update of the beneficiary's dental and medical history, clinically appropriate charting necessary to update and supplement the comprehensive oral examination data, including periodontal screening and appropriate radiographs as necessary to update previous radiograph surveys (radiographs are separately reimbursable). A periodic oral evaluation is a covered benefit once every six months for all beneficiaries, but may not be billed within six months of a Comprehensive Oral Evaluation.	Clarification.
Hospital	1.3 Third Party Liability	Subsection text was revised to read: Federal regulations require that all identifiable financial resources available for payment, including Medicare, be billed prior to billing Medicaid. (Refer to the Coordination of Benefits chapter for additional information.)	Revised language will maintain consistency throughout the Manual.
Hospital	4.3 Confidentiality	The following text was added at the end of the paragraph: (Refer to the Directory Appendix for MDCH hospital audit contractor contact information.)	MPRO contact information added to the Directory Appendix because MPRO was awarded the MDCH post-payment review hospital audit contract.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	1.5 Payment Calculation	The 2nd paragraph was revised to read: Refer to the Coordination of Benefits chapter for information regarding MDCH's payment liability.	Revised language will maintain consistency throughout the Manual.
Medical Supplier	1.7.B. Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Form	In the 5th paragraph, the 1st sentence was revised to read: The MSA-1656 must be submitted within 90 days of the date the evaluation was completed.	Clarification.
Medical Supplier	2.48.C. Prior Authorization for Purchase, Rentals, Repairs, and/or Replacement of Mobility Devices	Under "Clinical Documentation", the 1st sentence was revised to read: The evaluation and clinical documentation (MSA-1656) must be submitted within 90 days of the date the evaluation was completed.	Clarification.
Mental Health/ Substance Abuse	2.3 Location of Service	In the 5th paragraph, the 2nd sentence was revised to read: Medicaid does not cover services provided to children with serious emotional disturbance in Child Caring Institutions (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec.1(f) under Act No. 116 of the Public Acts of 1973, as amended, or it is for the purpose of transitioning a child out of an institutional setting (CCI).	This is clarification of the type of CCI that permits Medicaid coverage per Act 116, amended two to three years ago, for Children's Therapeutic Group Home as a category of CCI specifically for children with developmental disabilities or children with serious emotional disturbance.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	6.2.A. Child Crisis Residential Services	Subsection text was revised to read: Child Crisis Residential Services may not be provided to children with serious emotional disturbances in a Child Caring Institution (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec. 1(f) under Act No. 116 of the Public Acts of 1973, as amended. The program must include on-site nursing services (RN or LPN under appropriate supervision). On-site nursing must be provided at least one hour per day, per resident, seven days per week, with 24-hour availability on-call.	Per Act 116, Children's Therapeutic Group Home is defined in the statute as "not more than 6 children" so references to larger settings are not relevant.
Nursing Facility Coverages	9.1. Medicare-Covered Services	In the 1st paragraph, the 1st sentence was revised to read: For Medicare Part B covered services, ... The following text was added as the 2nd paragraph: Medicaid co-insurance payments for Part A are the lower of the co-insurance charge or the current maximum co-insurance rate established under the formula stated in the Social Security Act. The facility's total payments from Medicare, Medicaid and other insurance may be up to, but cannot exceed, the amount established by Medicare as reasonable (i.e., the amount allowed by Medicare).	Restore information inadvertently removed from Manual.
Nursing Facility Coverages	10.8.C. Prior Authorization	The 3rd sentence was revised to read: Facility clinicians who are responsible for the overall nursing plan of care for, and treatment of, the resident prepare and submit prior authorization requests, medical documentation, and the Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices form (MSA-1656) within 90 days of the date the evaluation was completed.	Clarification.
Nursing Facility Cost Reporting & Reimbursement Appendix	8.3.B. Enforcement Actions	The 5th bullet point was revised to read: • A state enforcement action is eliminated.	Update per Department of Licensing and Regulatory Affairs (LARA).

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CHAPTER	SECTION	CHANGE	COMMENT
Outpatient Therapy	5.3.C. Physician Referral for Speech Therapy	In the table in the 3rd paragraph, under "Initiation of Services", the 5th paragraph was revised to read: PA is not required for the first 12 consecutive calendar months in the outpatient setting	To correct/update information released in bulletin MSA 12-02.
Practitioner	1.6 Medicare Related Services	The 1st sentence was revised to read: MDCH reimburses practitioners for the coinsurance and deductible amounts ...	Revised language will maintain consistency throughout the Manual.
Practitioner	Section 7 - Emergency Services	The 2nd sentence was revised to read: Federal statutes prohibit prior authorization (PA) for coverage of emergency services.	Clarification that PA in this section refers to prior authorization (rather than Physician Assistant).
Program of All Inclusive Care for the Elderly	3.12 Provider Appeals	In the 1st paragraph, the 2nd sentence was revised to read: ... the PACE organization may appeal if their written request is received by the Michigan Administrative Hearing System within ...	Correction.
School Based Services	1.2 Third Party Liability	Subsection text was revised to read: Federal regulations require that all identifiable financial resources available for payment be billed prior to billing Medicaid. If a Medicaid-eligible child is presently covered by another resource and the school district does not bill the other resource, Medicaid cannot be billed for the services. (Refer to the Coordination of Benefits chapter for additional information.)	Revised language will maintain consistency throughout the Manual.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Provider Resources	Addition of: **Contact/Topic:** Hospital Post-Payment Reviews (MDCH Post-Payment Review Hospital Audit Contractor) **Phone #/Fax #:** 800-727-7223 **Mailing/Email/Web Address:** Michigan Peer Review Organization 22670 Haggerty Rd., Ste. 100 Farmington Hills, MI 48335-2611 **Information Available/Purpose:** Inpatient and outpatient hospital post-payment reviews.	MPRO contact information added to the Directory Appendix because MPRO was awarded the MDCH post-payment review hospital audit contract.
Directory Appendix	Reporting Fraud, Abuse, or Misuse of Services	Under Benefits Monitoring Program (BMP): Phone # revised to read: 855-808-0312 E-mail address added: BMP@michigan.gov	Update effective 10/1/2013.
Glossary Appendix	Practitioner	"Optometrist" was added to the Definition.	Clarification.
Forms Appendix	MSA-1656	On the Instructions page, 1st paragraph, the 2nd sentence was revised to read: The evaluation and justification must be submitted within 90 days of the date the evaluation was completed.	Clarification.
Forms Appendix	DCH-0078	Request to Add, Terminate or Change Other Insurance	Instructions were revised to include submission of form via on-line.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 13-27	8/5/2013	Children's Special Health Care Services	9.8 Health Insurance Program (HIP) Enrollment	Subsection was deleted. Following subsection was re-numbered.
		Acronym Appendix		Deletion of: HIP - Health Insurance Program
MSA 13-25	8/2/2013	Hospital Reimbursement Appendix	13.4.B. Medicaid Eligible Patient Volume	The 6th sentence was revised to read: For purposes of measuring Medicaid eligible patient volume, an inpatient hospital day or hospital discharge with a Medicaid-enrolled patient, including those with no Medicaid payment liability, is considered an encounter.
MSA 13-24 and MSA 13-09	7/1/2013 and 3/1/2013	Mental Health/ Substance Abuse	3.1 Applied Behavior Analysis (new subsection)	New subsection text reads: Refer to the Applied Behavior Analysis Section of this chapter for specific program requirements. Following subsections were re-numbered.
			Section 19 - Applied Behavior Analysis (new section)	New section (and subsections) provide Autism policy.
		Acronym Appendix		addition of: ABA - Applied Behavior Analysis ABI - Applied Behavioral Intervention ABLLS-R - Assessment of Basic Language and Learning Skills - Revised ADI-R - Autism Diagnostic Interview - Revised ADOS-2 - Autism Diagnostic Observation Schedule - Second Edition ASD - Autism Spectrum Disorder BACB - Behavioral Analyst Certification Board BCaBA - Board Certified Assistant Behavior Analyst BCBA - Board Certified Behavior Analyst

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				BHDDA - Behavioral Health Developmental Disabilities Administration (MDCH) DAS-II - Differential Ability Scales-II DQ - Developmental Quotient DSM-5 - Diagnostic and Statistical Manual of Mental Disorders, 5th Edition DSM-IV - Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition DTT - Discrete Trial Training EIBI - Early Intensive Behavioral Intervention IQ - Intelligence Quotient MCL - Michigan Compiled Law NAC - National Autism Center PDD-NOS - Pervasive Developmental disorder - Not Otherwise Specified VABS-2 - Vineland Adaptive Behavior Scales - Second Edition VB-MAPP - Verbal Behavior-Milestones Assessment and Placement Program WPPSI-III - Wechsler Preschool and Primary Scale of Intelligence-III WPPSI-IV - Wechsler Preschool and Primary Scale of Intelligence-IV
		Directory Appendix	Other Health Care Resources/Programs	Addition of: Contact/Topic: National Autism Center (NAC) Web Address: http://www.nationalautismcenter.org/pdf/NAC%20Standards%20Report.pdf Information Available/Purpose: National Autism Center's National Standards Report, 2009
MSA 13-21	7/1/2013	Dental	6.1.E. Pre-diagnostic Services (insertion of new subsection; following subsections re-numbered)	

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			6.1.E.1. Oral Evaluation, Patient <3 Years (new subsection)	New subsection text reads: An oral evaluation of a patient <3 years of age is performed by a dentist preferably within the first six months of the eruption of the first primary tooth. An oral evaluation includes a clinical examination to identify disease, malformation, injury and caries risk. Counseling with the primary caregiver and the development of an appropriate preventive oral health plan are required. The oral evaluation of a patient <3 years may be billed in conjunction with other dental services, but may not be billed on the same date of service as other oral evaluation services.
			6.1.E.2. Screening of a Patient <3 Years (new subsection)	New subsection text reads: A screening of a patient <3 years is an inspection of the oral cavity by a medical provider to determine the need for referral to a dentist for evaluation and diagnosis. This includes state or federally mandated screenings. Counseling with the primary caregiver and referral (as needed) is required. The screening of a patient <3 years may be billed in conjunction with topical fluoride varnish applications, but may not be billed on the same date of service as other oral evaluation services.
			6.1.E.3. Assessment of a Patient (new subsection)	New subsection text reads: An assessment of a patient is a clinical evaluation performed by a dental hygienist operating in a public health setting or an approved Public Act 161 of 2005 (PA 161) program within the scope of dental hygiene practice to identify signs of disease, malformation or injury and the need for referral for diagnosis and treatment. An assessment must include written documentation of the beneficiary's dental and medical history. Written documentation of significant clinical findings and the appropriate referral is required. An assessment of a patient is a benefit for all ages. It can be billed in conjunction with other dental hygiene services, but may not be billed on the same date of service as other oral evaluation services.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			6.4.G. Retreatment of Previous Root Canal Therapy (new subsection)	New subsection text reads: Retreatment of previous root canal therapy is a covered benefit for beneficiaries under age 21 once per tooth per lifetime. Prior authorization is required. Retreatment requires the removal of all previous root canal materials and the necessary preparation of the canals for new root canal filling materials. It includes all procedures necessary for complete root canal therapy and should be considered prior to performing an apicoectomy. Prior authorization requests must include a periapical image and documentation of the reason for retreatment. Following subsection was re-numbered.
MSA 13-19	6/1/2013	Home Health	1.1 Face-to-Face Encounter (new subsection)	New subsection text reads: A physician certifying eligibility for home health services must provide documentation of a face-to-face encounter with the beneficiary within 90-days prior to or 30-days after the start of care. The face-to-face encounter may occur through telehealth in compliance with Section 1834(m) of the Social Security Act. NOTE: The face-to-face encounter requirement pertains only to initial certification for home health services. Only a physician may order home health services and certify a beneficiary's eligibility for the benefit. The face-to-face encounter ensures that the orders and certification for home health services are based on current knowledge of the beneficiary's clinical condition, and will identify the primary reason for home health services. In a situation where a physician orders home health services based on a new condition that was not evident during a visit within the 90-days prior to the start of care, the certifying physician or non-physician practitioner (NPP) must see the beneficiary within 30 days of admission to home health services. The certifying physician must document the face-to-face encounter regardless of whether the physician or a permitted NPP performed the encounter. When the face-to-face encounter is performed by a NPP, he/she must document the clinical findings of the face-to-face encounter and communicate those findings to the physician; the physician must then sign the certification.

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				Permitted NPPs include: • A nurse practitioner or clinical nurse specialist (as defined in section 1861(aa)(5) of the Social Security Act) who is working in collaboration with the physician in accordance with state law; • A certified nurse-midwife (as defined in section 1861(gg) of the Social Security Act, as authorized by State law); or • A physician assistant (as defined in section 1861(aa)(5) of the Social Security Act) under the supervision of the physician. The face- to-face beneficiary encounter must be a separate and distinct section of, or an addendum to, the certification and must be clearly titled, dated and signed by the certifying physician. Use of a specific form for the certification or the plan of care is not required. Documentation of the face-to-face encounter must reflect the certifying practitioner's assessment of the beneficiary and include: • Date of the encounter, • Primary reason for the encounter (medical condition), • Clinical findings that support the need for skilled nursing or therapy services, and • Clinical findings that support home health eligibility. An addendum may consist of clinical documents from a hospital or post-acute facility (e.g., emergency visit record or discharge summary). It is allowable for the certifying physician to use such a document as an addendum for the face-to-face encounter if: • The addendum contains all of the documentation requirements for face-to-face documentation;

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				• The addendum document, which is serving as the face-to-face documentation, is clearly titled and dated as such; and • The certifying physician signs and dates the addendum, demonstrating that the certifying physician received that information from the allowed NPP or physician who performed the face-to-face encounter, and that the certifying physician is using that addendum document as his/her documentation of the face-to-face encounter. While typically the same physician will certify, establish and sign the POC, it is allowable for physicians who attend to the beneficiary in the acute and post-acute settings to certify the need for home health care based on their face-to-face contact, initiate the orders (POC) for home health services, and "hand off" the beneficiary's care to the community-based physician to review and sign off on the plan of care.
		Practitioner	5.4.A. Physician Order for Care	The following text was added as the 2nd paragraph: For initial certification, a physician certifying eligibility for home health services must provide documentation of a face-to-face encounter with the beneficiary within 90 days prior to or 30 days after the start of care. Refer to the Face-to-Face Encounter section in the Home Health Chapter for additional information.
		Acronym Appendix		Addition of: NPP - Non-physician practitioner
MSA 13-18	6/1/2013	Beneficiary Eligibility	3.1 CHAMPS Eligibility Inquiry	In the 3rd paragraph (NOTES:), the 3rd bullet point was revised to read: • The CHAMPS Eligibility Inquiry and 270/271 response will report the HIPAA Service Type code for services covered under each Benefit Plan and any applicable copay amounts. A generic or explicit response will be returned, determined by the type of inquiry (generic or explicit) received through the electronic 270 eligibility request. Always refer to the applicable chapters ...

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MSA 13-17	6/1/2013	General Information for Providers	1.9 Claims Processing System	In the 3rd sentence, "ordering/referring provider verification" was added to the function list.
			2.2 Enrollment Application Fees (new subsection)	Text reads: Enrollment application fees are required from all institutional providers, as defined by the Centers for Medicare & Medicaid Services (CMS). Individual physicians and non-physician practitioners are not considered institutional providers and, as such, are not subject to an application fee. Providers who are enrolled in or have paid the application fee to Medicare or another state's Medicaid or Children's Health Insurance Program (CHIP) are not required to pay an application fee to the Michigan Medicaid Program. The fee is required for each enrolled provider type at the time of initial enrollment and re-enrollment. The fee is not required for revalidation or interim updates to provider enrollment information. The application fee amount is established by CMS and updated annually.
			7.2 Nonenrolled Michigan and Borderland Providers	The 2nd paragraph was revised to read: All providers (except pharmacies) rendering, ordering, prescribing, or referring services to Michigan Medicaid beneficiaries must be enrolled/registered in the Michigan Medicaid program. (Refer to the Directory Appendix for contact information related to the on-line application process.) Exceptions to this requirement ...
			8.5 Service Acceptability	In the 1st paragraph, the 1st sentence was revised to read: MDCH may determine that a provider did not order, prescribe, refer, or render services/items within the scope of currently accepted ...
			8.6 Ordering, Prescribing and Referring Services/Items (new subsection)	Text reads: All providers ordering, prescribing and/or referring services/items to Michigan Medicaid beneficiaries must be enrolled in the Michigan Medicaid program. These regulations apply to Fee for Service Medicaid, Medicaid Health Plans and Adult Benefits Waiver providers. Claims for beneficiaries with Medicare or private insurance coverage will not be exempt from this requirement. (Refer to the specific Billing & Reimbursement chapters for additional information.)

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			10.2.D. Reimbursement	In the 3rd paragraph, the 7th bullet point was revised to read: • The service/item was ordered, prescribed or referred by a provider who has been sanctioned, and the sanction was in effect before PA was granted. and an 8th bullet point was added: • The service/item was ordered, prescribed, or referred by a non-enrolled provider.
			12.1 Billing Provider	In the 1st paragraph, the 2nd and 3rd sentences were revised to read: For payment, MDCH requires the provider name and NPI numbers to be reported in any applicable provider loop or field (e.g., attending, billing, ordering, prescribing, referring, rendering, servicing, supervising, etc.) on the claim. It is the responsibility of the attending, ordering, prescribing, referring or supervising provider to share their name, NPI and Michigan Medicaid Program enrollment status with the provider performing the service.
			15.2 Provider's Orders	The subsection was re-named to "Orders, Prescriptions and Referrals." Text was revised to read: Providers arranging or rendering services upon the order, prescription or referral of another provider (e.g., physician) must maintain that order, prescription and/or referral for a period of seven years.
			15.7 Clinical Records	In the table after the 5th paragraph, information in the 1st column was revised to read: (7th row): Records of Medications, Drugs, Assistive Devices or Appliances, Therapies, Tests and Treatments that are Ordered, Prescribed, Referred or Rendered (15th row): Ordering, Prescribing or Referring Physician
			Section 16 - Post-Payment Review and Fraud/Abuse	The 2nd sentence was revised to read: Post-payment reviews of paid claims may be conducted to assure that all services/items, providers, and settings were appropriate, necessary, and comply with Medicaid policy.

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		Coordination of Benefits	3.4 Claims Subject to Additional Edits (new subsection)	Text reads: If a beneficiary has Medicare or private insurance, submitted claims must contain the name and individual National Provider Identifier (NPI) of the practitioner who ordered, prescribed or referred the service(s)/item(s). If the applicable attending, ordering, prescribing or referring provider information is not reported on the claim, or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid.
		Billing & Reimbursement for Dental Providers	3.3 Reporting Provider NPI	The 4th paragraph was revised to read: MDCH NPI claim editing will be applied to the billing, referring, and/or rendering provider as applicable. A claim cannot be paid if the NPI is missing or ... A 5th paragraph was added: The ADA claim form does not contain fields for the referring provider. Paper claims which require this information must be submitted via CHAMPS Direct Data Entry (DDE). (Refer to the Directory Appendix for additional information.)
			3.3.C. Referring Provider	Subsection text was revised to read: Referring provider information is a claim editing requirement for services rendered as a result of a referral. The claim must contain the name and individual NPI of the provider who referred the service(s)/item(s). If referring provider information is not reported on the claim, or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid. Rendering providers should ensure their referral sources are aware of this requirement. Referring providers may initiate the enrollment process at any time. (Refer to the General Information for Providers chapter for information regarding enrollment.)
		Billing & Reimbursement for Institutional Providers	2.3 Reporting Provider NPI	In the 1st paragraph, the 1st sentence was revised to read: MDCH requires that NPI numbers be reported in any applicable provider loop or field (e.g., attending, billing, referring, and rendering) on the claim.

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				The 4th paragraph was revised to read: MDCH NPI claim editing will be applied to the attending, billing, referring and rendering provider, as applicable. A claim cannot be paid if the NPI is missing or the reported NPI is invalid as it does not check digit and/or correctly crosswalk to the Provider Enrollment files for these provider loops or fields.
			2.3.B. Attending Provider	Text after the 1st sentence was revised to read: For all institutional claims, the attending physician must be Medicaid enrolled. If the attending physician information is not reported on the claim or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid. Rendering providers should ensure their referral sources are aware of this requirement.
			2.3.C. Referring Provider (new subsection)	Text reads: If a referring provider is required to be submitted, use the appropriate Form Locator field for claim completion.
		Billing & Reimbursement for Professionals	Section 1 - General Information	The following text was added as a 3rd paragraph: Claims for services rendered as a result of an order or referral must contain the name and individual NPI of the provider who ordered or referred the service/item. The following are the authorized health professionals who may order, prescribe or refer services to Medicaid beneficiaries: • Physician • Physician Assistant • Nurse Practitioner • Certified Nurse Midwife • Dentist • Podiatrist

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				• Optometrist • Chiropractor (limited to spinal x-rays only) The following text was added as a 4th paragraph: Examples of services that require an order, prescription or referral include, but are not limited to,: • Ambulance nonemergency transports • Ancillary services for beneficiaries residing in nursing facilities (e.g., chiropractic, dental, podiatry, vision) • Childbirth/parenting and diabetes self-management education • Consultations • Diagnostic radiology services, unless rendered by the ordering physician • Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) • Hearing and hearing aid dealer services • Home health services • Hospice services • Laboratory services • Certain mental health and substance abuse children's waiver services • Certain Maternal Infant Health Program (MIHP) services • Pharmacy services • Private Duty Nursing services • Certain School Based Services • Therapy services (occupational therapy (OT), physical therapy (PT) and speech) • Certain vision supplies

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			2.3.B. Rendering Provider	The 1st and 2nd sentences were revised to read: For claims requiring a rendering provider, the loop or field is mandatory. The rendering provider must be enrolled with the program for payment. If the referring provider information is not reported on the claim, or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid.
			2.3.C. Referring Provider	Subsection was re-named: Referring/Ordering Provider Subsection text was revised to read: Referring/ordering provider information is a claim submission requirement for all services rendered as a result of a referral/order. The claim must contain the name and individual NPI of the provider who referred/ordered the service(s)/item(s). If the referring/ordering provider information is not reported on the claim, or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid. Rendering providers should ensure their referral sources are aware of this requirement.
			6.3 Ambulance	Under "Wait Time", the 2nd bullet point was revised to read: • Name and NPI of the physician ordering the wait.
			6.9 Evaluation and Management	Under "Consultations", text was revised to read: Consultations require the referring/ordering provider's name and NPI in items 17 and 17b.
			6.14 Laboratory Services	Under "Referring/Ordering Provider", text was revised to read: All clinical lab services billed to Medicaid must have a referring/ordering Medicaid provider name and NPI in items 17 and 17b.

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		Children's Special Health Care Services	2.2.B. Providers Not Requiring Authorization	The last sentence was revised to read: The name and NPI of the CSHCS authorized ordering or prescribing provider must be entered in the appropriate field on the claim.
		Pharmacy	1.7 Medicaid Health Plans and ABW County Health Plans	In the 3rd paragraph, the following text was inserted after the 1st sentence: All plan providers are required to enroll/register in CHAMPS.
			1.7.A. Carve-Out Exceptions	The following text was added as a 2nd paragraph: Any services paid Fee For Service must follow appropriate guidelines for supporting documentation, including attending, billing, prescribing, referring, rendering and supervising provider requirements.
		Urgent Care Centers	3.1 NPI Edits	Subsection text was revised to read: MDCH NPI claim editing will be applied to attending, billing, referring, rendering and supervising providers, as applicable. A claim cannot be paid if the NPI is missing or the reported NPI is invalid as it does not check digit and/or correctly crosswalk to the Provider Enrollment files for these provider loops or fields.
MSA 13-16	6/1/2013	Nursing Facility Certification, Survey & Enforcement Appendix	2.3 Criteria for Evaluation of Medicaid Bed Certification Requests	In the 1st paragraph, bullet points were revised to read: • (2nd bullet point) ... The nursing facility has not been subject to one of the following actions or concerns within two years (or as noted) ... • (2nd bullet point, 5th sub-bullet point) ... Immediate Jeopardy levels, issued within the last two years or two standard survey cycles. • (2nd bullet point, 6th sub-bullet point) ... A number of citations at Level Two or above on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average number of citations. (The time frame for this criterion may exceed two years.)

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MSA 13-14	5/1/2013	Nursing Facility Cost Reporting & Reimbursement Appendix	5.2 Plant Cost Certification Submission	The 3rd paragraph was revised to read: Supporting documentation must include the following items for a transfer of ownership of a license, acquisition, or lease that requires CON approval: • CON Approval Letter • Purchase Agreement • Mortgage and Loan Agreements • At least 36 months of Interest Amortization Schedules for Financing prepared by the lender • Property Tax Statements • Capital Asset Cost Appraisal • Purchase Closing Statement or Recording The 4th paragraph was revised to read: Supporting documentation must include the following items, where applicable, for a renovation, addition, or new construction: • CON Approval Letter (if CON approval is required) • Licensed Bed Notice issued by the State Survey Agency • Mortgage and Loan Agreements, if applicable • At least 36 months of Interest Amortization Schedules for Financing prepared by the lender • Property Tax Statements • Construction Contract Statement or Summary

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MSA 13-13	5/1/2013	Federally Qualified Health Centers	3.4 Substance Abuse Coordinating Agency	Subsection text was revised to read: Selected services described in the MOA provided by an FQHC will be included in the FQHC annual reconciliation when a contract exists between the FQHC and the behavioral health contracting entity. FQHCs that have a contract in place with a behavioral health agency must follow the service and billing arrangements set forth by the contract.
MSA 13-09	3/1/2013	Practitioner	3.5 Developmental/ Behavioral Screening	In the 2nd paragraph, the 3rd bullet point was revised to read: A validated screening tool must be administered as part of the well-child visit by the pediatrician or family physician as recommended by the AAP. Proper assessment of autism is accomplished by administering a validated standardized screening tool, such as the Modified Checklist for Autism in Toddlers (M-CHAT), at 18 and 24 months of age as indicated by the AAP Periodicity Schedule. Surveillance for Autism Spectrum Disorder (ASD) must be completed at other well-child visits beginning at 12 months of age by listening for parent concerns and by watching for red flag abnormalities, such as no babbling by 12 months of age. Children older than 24 months of age who have not been screened may be screened at preventive care visits using a validated standardized screening tool such as the M-CHAT or the Social Communication Questionnaire (SCQ). The screening tool may be completed by the parent and reviewed/verified by the practitioner. The M-CHAT is validated for toddlers 16 through 30 months of age. For children older than 4 years of age (mental age greater than 2 years of age), the SCQ may be utilized. For children 30 months through 4 years of age, the most applicable of the two tools should be administered (M-CHAT if mental age is less than 2 years of age; SCQ if mental age is greater than 2 years of age).

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			3.10 Referrals	In the table in the 3rd paragraph, the following text was added: **Autism Spectrum Disorders**: The primary care physician (PCP) who screened the child for ASD and determined a referral for further evaluation was necessary will contact the Pre-paid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. The PCP must refer the child to the PIHP in the geographic service area for Medicaid and MIChild beneficiaries. (Refer to the Mental Health/Substance Abuse chapter for the treatment of children with autism.)
MSA 12-55	11/1/2012	General Information for Providers	Section 2 - Provider Enrollment	The following text was inserted after the 8th paragraph: All providers are required to revalidate their Medicaid enrollment information a minimum of once every five years, or more often if requested by MDCH. MDCH will notify providers when revalidation is required. Providers must notify MDCH within 35 days of any change to their enrollment information.
			2.1 Provider Ownership and Control Disclosures (new subsection)	Text reads: Provider enrollment information, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).
			2.1.A. Required Disclosure Information (new subsection)	Text reads: Providers (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation, and within 35 days after any change in ownership: • The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location, and P.O. Box address.

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				• Date of birth and Social Security Number (in the case of an individual). • Other Tax Identification Number, in the case of a corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest. • Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling. • The name of any other fiscal agent or managed care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare. • The name, address, date of birth and Social Security Number of any managing employees.
			2.1.B. Criminal Offense Notification (new subsection)	Text reads: Providers must notify the state licensing agency and MDCH Provider Enrollment of any person(s) with an ownership or controlling interest in a facility that has been convicted of a criminal offense related to their involvement in any programs under Medicare, Medicaid, or Social Services Block Grants since the inception of these programs.
			2.3 Enrollment Screening (new subsection)	Text reads: MDCH conducts Medicaid provider enrollment screening per federal rules and regulations.
			2.3.A. Provider Categorical Risk Enrollment Screening (new subsection)	

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<tr><td></td><td></td><td></td><td>2.3.A.1. Categorization of Providers Based on Level of Risk

(new subsection)</td><td>Text reads:

Provider types must be categorized based on the potential risk of fraud, waste, and abuse to the Medicaid Program. MDCH has adopted the risk categorization established by the Centers for Medicare & Medicaid Services (CMS) for provider types. For all other provider types, MDCH establishes the risk level. A provider's categorical risk level may be adjusted to "high" due to payment suspension, overpayment status, or Office of Inspector General (OIG)/Medicaid Program exclusion status and after listing of a temporary moratorium.</td></tr>
<tr><td></td><td></td><td></td><td>2.3.A.2. Screening Activities Based on Risk Category and Provider Type

(new subsection)</td><td>Text reads:

Additional provider screening activities are required and will be conducted based on the provider's categorical risk level. The following table summarizes the general screening activities by risk category and type of provider.

<table>
<tr><th>Category</th><th>Type of Provider</th><th>Screening Activities</th></tr>
<tr><td>High</td><td>• Prospective (newly enrolling) home health agencies
• Prospective (newly enrolling) DMEPOS suppliers</td><td>• Fingerprint based criminal background checks
• Unannounced pre- and post-enrollment site visits
• Verifications, including licensure, Social Security Number, Taxpayer Identification Number, National Provider Identifier (NPI), OIG exclusion status, and information regarding disclosed individuals</td></tr>
</table>
</td></tr>
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<table>
<tr><th>Category</th><th>Type of Provider</th><th>Screening Activities</th></tr>
<tr><td>Moderate</td><td>• Ambulance services
• Community Mental Health centers
• Comprehensive Outpatient Rehabilitation Facilities (CORFs)
• Hospice organizations
• Independent clinical laboratories
• Physical therapists enrolling as individuals or as group practices
• Revalidating home health agencies
• Revalidating DMEPOS suppliers</td><td>• Unannounced pre- and post-enrollment site visits
• Verifications, including licensure, Social Security Number, Taxpayer Identification Number, NPI, OIG exclusion status, and information regarding disclosed individuals</td></tr>
<tr><td>Limited</td><td>• All other provider types</td><td>• Verifications, including licensure, Social Security Number, Taxpayer Identification Number, NPI, OIG exclusion status, and information regarding disclosed individuals</td></tr>
</table>
</td></tr>
<tr><td></td><td></td><td></td><td>2.3.B. Site Inspections (new subsection)</td><td>Text reads:

All enrolled providers must permit unannounced on-site inspections as a condition of participation. MDCH will conduct pre-enrollment and post-enrollment site visits of providers designated as "moderate" and "high" categorical risk. (Refer to the Provider Categorical Risk Enrollment Screening subsection within this chapter for further information.)</td></tr>
</table>

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			2.3.C. Criminal Background Checks (new subsection)	Text reads: All enrolled providers, or any person with a five percent or more direct or indirect ownership interest in the provider, must consent to criminal background checks, including fingerprinting, as a condition of participation. MDCH will conduct criminal background checks and will require submission of fingerprints from providers designated as "high" categorical risk when directed by CMS.
			2.3.D. Verification of Provider Information (new subsection)	Text reads: MDCH conducts verifications, including licensure, Social Security Number, Taxpayer Identification Number, NPI, information regarding disclosed individuals, OIG exclusion status, and other databases, as required.
			2.4 Temporary Moratoria on Enrollment (new subsection)	Text reads: A temporary moratoria, numerical caps, or other limits may be placed on the enrollment of new providers or provider types identified as having a significant potential or increased risk for fraud, waste, or abuse as long as it would not adversely impact beneficiary access to medical assistance.
			Section 3 - Maintenance of Provider Information	In the 1st paragraph, the 3rd sentence was revised to read: Providers must notify MDCH via the on-line system (or MDCH PBM Provider Enrollment Unit for pharmacies) within 35 days of any change to their enrollment information.

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			Section 5 - Compliance with Federal Legislation	Section was re-named: Nondiscrimination Text was re-located from 5.2 Nondiscrimination and reads: Federal regulations require that all programs receiving federal assistance through Health and Human Services (HHS) comply fully with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Providers are prohibited from denying services or otherwise discriminating against any medical assistance recipient on the grounds of race, color, national origin or handicap. For complaints of noncompliance, contact the Michigan Department of Civil Rights or the Office for Civil Rights within the U.S. Department of Justice. (Refer to the Directory Appendix for contact information.)
			5.1 Disclosure	Subsection was deleted. Information was relocated to new subsection: 2.1.B. Criminal Offense Notification.
			5.2 Nondiscrimination	Subsection was deleted. Information was relocated to Section 5 - Nondiscrimination.
			Section 6 - Termination of Enrollment	Section was re-named: Denial of Enrollment, Termination and Suspension
			6.1 General Information	Subsection was re-named: Termination or Denial of Enrollment The 1st and 2nd paragraphs were revised to read: MDCH may terminate or deny enrollment in the Michigan Medicaid program. Termination of enrollment means a provider's billing privileges have been revoked and all appeal rights have been exhausted or the timeline for appeal has expired. Denial of enrollment means the provider's application will not be approved for participation in the Medicaid program. The basis for termination or denial of enrollment includes, but is not limited to,: • Failure to submit timely and accurate information;

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				• Failure to cooperate with MDCH screening methods; • Conviction of a criminal offense related to Medicare, Medicaid, or the Title XXI program in the last 10 years; • Termination on or after January 1, 2011 under Medicare or the Medicaid program, or the Children's Health Insurance Program (CHIP) of any other state; • Failure to submit sets of fingerprints as required within 30 days of a CMS or MDCH request; • Failure to permit access to provider locations for site visits; • Falsification of information provided on the enrollment application; or • Inability to verify a provider applicant's identity. Providers may appeal the decision to terminate or deny enrollment. Denial of enrollment due to a temporary enrollment moratorium is appealable, but the scope of review is limited to whether the temporary moratorium applies to the provider appealing the denial. The basis for imposing a temporary moratorium is not subject to review. After termination from the Medicaid program, the provider must contact MDCH to request re-enrollment as a Medicaid provider and reinstatement of billing privileges. Providers whose enrollment has been denied are not prohibited from submitting a subsequent re-enrollment application.
			6.2 Loss of Licensure	In the 3rd paragraph, the 1st sentence was revised to read: If a provider is no longer licensed to practice (e.g., the license was suspended, lapsed or revoked), MDCH does not reimburse for services ordered, prescribed, referred or rendered by that provider after the termination of the license.

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			6.3 Payment Suspension (new subsection)	Text reads: MDCH may temporarily suspend payments to a provider after determining there is a credible allegation of fraud for which an investigation is pending under the Medicaid program. An allegation of fraud may be from any source, including fraud hotline complaints, claims data mining and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indications of reliability and the State Medicaid Agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. Providers will be notified within 90 days of initiation of payment suspension. The notification will include the general allegations as to the nature of the suspension action, the period of suspension, and the circumstances under which the suspension will be terminated. Providers may submit written evidence for consideration through the administrative appeal process. All payment suspensions will include referral to the MDCH Office of Health Services Inspector General.
			7.1 Sanctioned Providers	The subsection was revised and reformatted to read: Pursuant to Section 1128 and Section 1902(a) (39) of the Social Security Act, Medicaid does not reimburse providers for any services/items that were ordered, prescribed, referred or rendered by sanctioned (suspended, terminated, or excluded) providers. If a provider is presented with an order, prescription or referral from a sanctioned provider, that provider should inform the beneficiary that the service/item cannot be provided because the provider has been excluded from Medicaid participation. The beneficiary may elect to purchase the service/item after being notified of the provider's sanction and agrees, in writing, to pay for the service/item out of pocket. Provider sanctions may be initiated by MDCH, the U.S. Department of Health and Human Services (HHS) (i.e., Medicare), or other sanctioning body. Notice of a provider's sanction is provided in a cumulative list of sanctioned providers and is available on the MDCH website. (Refer to the Directory Appendix for website information.)

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				It is recommended providers check the MDCH Sanctioned Provider List on the MDCH website, as well as the websites of other sanctioning bodies, to avoid accepting orders, prescriptions or referrals for Medicaid beneficiaries from these sanctioned providers. Although MDCH makes every attempt to publish timely, accurate information about sanctioned providers, a sanctioned provider is excluded from Medicaid participation even if that provider has not been included on Medicaid's list of sanctioned providers. Any payments that may be unintentionally made to a sanctioned provider or a provider acting on an order, prescription or referral from a sanctioned provider must be refunded to Medicaid.
		Billing & Reimbursement for Professionals	2.3 Reporting Provider NPI	In the 1st paragraph, the 1st sentence was revised to read: MDCH requires that NPI numbers be reported in any applicable provider loop or field (e.g., billing, referring/ordering, rendering and supervising) on the claim. The 4th paragraph was revised to read: MDCH NPI claim editing will be applied to the billing, referring/ordering, rendering, and supervising provider, as applicable. A claim cannot be paid if the NPI is missing or the reported NPI is invalid as it does not check digit and/or correctly crosswalk to the Provider Enrollment files for these provider loops or fields.
MSA 12-49	10/1/2012	Hospital Reimbursement Appendix	7.4 Calculation of DSH Ceiling	The 2nd paragraph was revised to read: The DSH ceiling calculation is: Title XIX charges x Title XIX cost to charge ratio = Title XIX costs Uninsured charges x hospital specified cost to charge ratio = uninsured costs Title XIX payments + uninsured payments + pool payments = total payments Title XIX costs + uninsured costs – total payments = DSH ceiling

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				The following trend factors will be applied to the financial elements used to calculate hospital DSH ceilings during the Initial DSH Calculation for each year: • Base Year Cost Inflation – Inflation of base year costs (inpatient and outpatient) is computed using the Global Insight index of inflation for the entire hospital. Hospital costs are inflated from the hospital FYE to the current state FYE. Inflation of payments is computed from the hospital's rate change over time. • Base Year Utilization Trend – Hospital costs and payments are also adjusted from the state base year to the state current year end by the percentage change in the projected annual average Medicaid enrollment between the two periods.
			7.5 Disproportionate Share Hospital (DSH) Process (new subsection)	New subsection text reads: The DSH process is designed to mitigate DSH audit-related recoveries. It is a multiple-step process that allows hospitals to provide input into the DSH calculations, decline DSH funds, and reduce their DSH ceiling. The multiple-step DSH process is as follows. ***Step 1: Initial DSH Calculation*** MDCH will calculate hospital-specific DSH ceilings, DSH payment allocations and Medicaid utilization rates as part of its Initial DSH Calculation. Inpatient and outpatient data from the hospital's cost reporting period ending during the second previous state FY will be used for the DSH ceiling, DSH payment and Medicaid utilization rate calculations. The data will be trended to the current FY for DSH ceiling calculation purposes. For example, data from hospital cost reports with FYs ending between October 1, 2009 and September 30, 2010 will be used to complete the FY 2012 Initial DSH Calculation.

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				MDCH will share Initial DSH Calculations with hospitals. Hospitals will be able to decline DSH funds following the Initial DSH Calculation findings. If a hospital declines DSH funds during the Initial DSH Calculation step, the decision is irrevocable and the hospital is not eligible for any DSH funds for that state FY. Hospitals may also request a downward adjustment to their DSH ceiling during the Initial DSH Calculation step. Upon receipt of this feedback from hospitals, each hospital's calculated DSH ceiling will be reduced to the requested amount. No hospital will receive a DSH payment in excess of its initial DSH ceiling. DSH payments will be applied against a hospital's DSH ceiling in the following order: 1. $45 Million Pool 2. Outpatient Uncompensated Care DSH Pool 3. University with Both a College of Allopathic Medicine and a College of Osteopathic Medicine Pool (University Pool) 4. Indigent Care Agreements Pool (ICA Pool) 5. Government Provider DSH Pool (GP DSH Pool) ***Step 2: Interim DSH Settlement*** DSH ceilings, DSH payments and Medicaid utilization rates are recalculated using new cost report data during the Interim DSH Settlement step to mitigate final DSH audit-related DSH recoveries. This may result in DSH recoveries for some hospitals. DSH funds will be reallocated in a manner that maintains the pool order outlined in the Initial DSH Calculation step. As part of the Interim DSH Settlement, MDCH will recalculate hospital-specific DSH ceilings, DSH payment allocations and Medicaid utilization rates during the year following the applicable DSH year. Inpatient and outpatient data from cost reports with hospital FYs ending during the previous calendar year will be utilized for ceiling, payment, and Medicaid utilization rate recalculations. The data will not be trended. For example, during 2013, data from hospital cost reports with FYs ending between January 1, 2012 and December 30, 2012 will be used to complete the FY 2012 Interim DSH Settlement calculations.

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				MDCH will share Interim DSH Settlement results with hospitals. Hospitals are able to decline DSH funds following the Interim DSH Settlement. If a hospital declines DSH funds during the Interim DSH Settlement step, the decision is irrevocable and the hospital is not eligible for any DSH funds for that state FY. Hospitals may also request a downward adjustment to their DSH ceiling during the Interim DSH Settlement step. Upon receipt of this feedback from hospitals, each hospital's calculated DSH ceiling will be reduced to the requested amount and Interim DSH Settlement payments will be issued. Funds recovered from the $45 Million Pool and Outpatient Uncompensated Care DSH Pool are reallocated to other qualifying hospitals within that pool based on the original formula used to allocate funding from the pool. Funds recovered from the ICA Pool will be reallocated to other qualifying hospitals within that pool. No hospital will receive a DSH payment in excess of its Interim DSH Settlement ceiling. ***Step 3: Final DSH Audit-Related DSH Redistribution*** If the Final DSH Audit determines that a hospital has been paid in excess of its hospital-specific DSH ceiling, funds will be recovered from hospitals in the following order: 1. Funds from pools allocated exclusively to state government-owned or -operated or non-state government-owned or -operated public hospitals 2. All other DSH pools MDCH will recoup all payments that exceed audited hospital-specific DSH ceilings in the order stated above and then apply the following redistribution process. Only funds that exceed the audited hospital-specific DSH ceiling will be recovered and redistributed:

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				1. Funds recovered from pools allocated exclusively to state government-owned or -operated, or non-state government-owned or -operated public hospitals are reallocated to other like hospitals up to the lesser of the audited hospital-specific ceilings or other federal limits. No hospital is to receive a DSH payment that exceeds its audited hospital-specific DSH ceiling. Unspent DSH funds will be added to the "All Other DSH Pools" described in Step 2 below. The formulas to redistribute these recouped funds are as follows: a. (Eligible Hospital's Remaining Audited DSH Ceiling Capacity) / (∑ of all Eligible Hospitals' Audited Remaining DSH Ceiling Capacity) = (Hospital Pool Factor) b. (Hospital Pool Factor) x (Pool Amount) = Pool Payment 2. Funds recovered from the other DSH pools, plus any unspent DSH funds recouped from pools allocated exclusively to state government-owned or -operated, or non-state government-owned or -operated public hospitals, are reallocated to all remaining eligible hospitals proportionately based on their share of remaining audited hospital-specific DSH ceiling capacity adjusted to exclude the DSH payment amounts hospitals received from the ICA, University and GP DSH Pools during the Initial DSH Calculation and Interim DSH Settlement steps. No hospital will receive an allocation in excess of its remaining audited hospital-specific DSH ceiling capacity. The formulas to redistribute these recouped funds are as follows: a. (Eligible Hospital's Remaining Audited DSH Ceiling Capacity + ICA DSH Payment Amount + University DSH Payment Amount + GP DSH Payment Amount) / (∑ of all Eligible Hospitals' Audited Remaining DSH Ceiling Capacity + ICA DSH Payment Amount + University DSH Payment Amount + GP DSH Payment Amount) = (Hospital Pool Factor) b. (Hospital Pool Factor) x (Pool Amount) = Pool Payment

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				Pool payments calculated for individual hospitals that are in excess of a hospital's audited DSH ceiling will be placed back into that pool. These payments will then be reallocated to the remaining hospitals in that component of the pool which have not exceeded their audited hospital-specific DSH ceiling capacity. The reallocation will be based on the funding formula specified above. Only hospitals with available audited DSH ceiling capacity will be included.
			7.5.A. Distribution of DSH Payments for Merged Hospitals (previously numbered as 7.5)	Subsection was re-numbered from 7.5 to 7.5.A. Subsection text was revised to read: When two or more hospitals merge, eligibility for DSH payments after the merger is based on the combined cost report data of the merged hospitals.

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