MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 13-48

Distribution: All Providers

Issued: November 26, 2013

Subject: Updates to the Medicaid Provider Manual; 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 January 2014 quarterly update of the Michigan Medicaid Provider Manual. The Manual is maintained on the MDCH website at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual. A compact disc (CD) version of the Manual is available to enrolled providers upon request.

The January 2014 version of the Manual does not highlight changes made in 2013. However, consistent with previous quarterly manual updates, tables attached to this bulletin describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change. Subsequent changes made for the April, July, and October 2014 versions of the manual will be highlighted within the text of the on-line manual.

ICD-10 Project Update

MDCH encourages providers to participate in scenario-based testing and assign ICD-10 diagnosis codes to medical scenarios that apply to their practice areas. Scenario-based testing can be accessed on the MDCH website at www.michigan.gov/5010icd10. Full-scale Business-to-Business (B2B) testing of ICD-10 coded claims and encounter transactions, including adjudication in the B2B Test environment, will begin in 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 check the MDCH website at www.michigan.gov/5010icd10 frequently for ICD-10 updates, including the schedule for virtual trainings, which can be accessed via the Medicaid Provider Training Sessions hyperlink under the Awareness & Training section of the website.

Manual Maintenance

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

Questions

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

Approved

Stephen Fitton, Director
Medical Services Administration

Michigan Department of Community Health

Medicaid Provider Manual
January 2014 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	Section 2 – Provider Enrollment	In the 2nd paragraph, the 1st sentence was revised to read: Providers (except managed care organizations) must have their enrollment approved … The 6th paragraph was revised to read: Managed Care Organizations must complete their enrollment process through their MDCH Contract Manager.	Updated to reflect that pharmacies are now enrolled through MDCH/CHAMPS, not through the Pharmacy Benefit Manager (PBM).
General Information for Providers	Section 3 – Maintenance of Provider Information	The 1st paragraph was revised to read: Maintenance of provider information is done through the CHAMPS PE online system. (Refer to the Establishing Provider Access in CHAMPS section for additional information.) Providers must notify MDCH via the on-line system within 35 days of any change to their enrollment information. (Refer to the Directory Appendix for CHAMPS PE access information.)	Updated to reflect that pharmacies are now enrolled through MDCH/CHAMPS, not through the PBM.
General Information for Providers	Section 3 – Maintenance of Provider Information	In the 2nd paragraph, the 12th bullet point was revised to read: • Addition/change of a specialty	Update.
General Information for Providers	4.2 Provider Profiles	In the chart in the 3rd paragraph, the following profiles were added for Pharmacy: • Provider Enrollment Access • Provider Enrollment View Access	Updated to reflect that pharmacies are now enrolled through MDCH/CHAMPS, not through the PBM.
General Information for Providers	7.2 Nonenrolled Michigan and Borderland Providers	In the 2nd paragraph: • The 1st sentence was revised to read: All providers rendering, ordering, … • Text after the 4th sentence was removed.	Updated to reflect that pharmacies are now enrolled through MDCH/CHAMPS, not through the PBM.
General Information for Providers	7.3 Out of State/Beyond Borderland Providers	In the 9th paragraph: • The 1st sentence was revised to read: All providers rendering services … • Text after the 3rd sentence was removed.	Updated to reflect that pharmacies are now enrolled through MDCH/CHAMPS, not through the PBM.

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CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	9.2 PACER Readmissions	The 4th paragraph was revised to read: If a PACER number is not provided for a readmission due to relatedness (required as a consequence of the original admission), the hospital must combine the two stays into a single episode for DRG payment purposes (using the Leave of Absence revenue code 0180 for the time between discharge and readmission), or request reconsideration of the ACRC physician/dentist advisor's decision within three business days. If the initial admission has already been billed, the hospital must submit a claim replacement to combine the two stays.	Action is required, not optional.
Beneficiary Eligibility	2.1 Benefit Plans	In the chart in the 2nd paragraph, information was placed in alphabetical order based on Benefit Plan ID. Revisions to Benefit Plan information are as follows: • HK-EXP: text revised to read "… up to 160% FPL. …" • MME-MC: Removal of Service Type Code 35	Updates.
Beneficiary Eligibility	8.2.D. Misutilization of Emergency Department Services	Addition of 3rd bullet point: • Utilizing covered services to obtain prescriptions for drugs subject to abuse and paying cash to obtain the drugs.	Edit of text removed in error.
Beneficiary Eligibility	8.7.A. All Providers	Subsection text was revised to read: Eligibility must be verified before providing service. BMP enrollees are indicated on the CHAMPS Eligibility Inquiry Response as additional information. If the BMP Provider Restriction Indicator is "Y", the hyperlink will be activated. The hyperlink will open the BMP Restrictions page which contains the BMP FFS and Managed Care Authorized Provider information.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
		When the beneficiary has FFS eligibility, the information in the BMP FFS Authorized Providers table directs payment. If there are no providers listed in the BMP FFS Authorized Providers table, the beneficiary is restricted only by the pharmaceutical refill tolerance for that date of service. The BMP may be contacted for additional information regarding covered services. FFS reimbursement for BMP enrollees is limited to exempt services, services provided by an active BMP FFS Authorized Provider per the beneficiary's eligibility file, and services provided by a referred provider when the following are present: • The beneficiary was referred by an active BMP FFS Authorized Provider; and • The referred provider has obtained a current Benefits Monitoring Program Referral (form MSA-1302) from the BMP FFS Authorized Provider. Rendering (and referring, when applicable) provider NPI numbers are required on claim submissions. **When the beneficiary is enrolled in a MHP,** the information in both the BMP FFS and Managed Care Authorized Providers tables is applicable. For FFS payment of services carved out of the MHP benefit, providers must be listed in the BMP FFS Authorized Providers table. The "Send to PBM" field must have a "Y" indicator for the prescribing physician for FFS payment of drugs subject to abuse which are carved out of the MHP benefit. The MHP may be contacted for additional information regarding covered services.	
Beneficiary Eligibility	8.10 Appeals	Subsection text was revised to read: Any written notice of a negative action or denial of a beneficiary's provider choice shall include reference to the beneficiary's right to appeal. The appeal process shall conform to Michigan Administrative Code (MAC) Rules R400.901 to R400.922. The MHP is the respondent in BMP-related hearings pertaining to actions taken by the MHP.	Clarification.
Coordination of Benefits	2.6.B. Medicare Part A	The 4th paragraph was revised to read: ... (Refer to the Directory Appendix for MDCH Provider Inquiry contact information.)	Providers should contact MDCH Provider Inquiry instead of the Buy-In Unit.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	6.2.J. Patient-Pay Amount	Information in the 2nd bullet point was revised/reformatted to read: • The facility must submit a claim to Medicaid even though the patient-pay amount is sufficient to cover the cost of the entire admission. • The facility must not bill the beneficiary for any balance between the facility charges and the patient-pay amount.	Clarification.
Ambulatory Surgical Centers	3.1 Payment Calculation	The 2nd paragraph was revised to read: The MDCH payment is the lesser of: • the Medicaid fee screen/allowable amount, minus any Medicare or other insurance payments, and any applicable Medicaid copayment, patient-pay, and/or deductible; or • (for fee schedule items) the provider's charge, reduced by any contractual adjustments, and minus any Medicare or other insurance payments, and any applicable Medicaid copayment, patient-pay, or deductible amount; or • the beneficiary's liability for coinsurance, copayments, and/or deductibles.	Edit of text removed in error.
Children's Special Health Care Services	9.2 General Dental Benefits	The 5th bullet point was deleted. The following text was added as a 3rd paragraph: **NOTE**: Hospital charges (e.g., general anesthesia, facility charges, etc.) may be covered for dental services provided through the inpatient or outpatient hospital facility for beneficiaries with certain CSHCS diagnoses even though CSHCS does not cover the dental care itself.	Clarification.
Children's Special Health Care Services	Section 10 – Out-of-State Medical Care	In the 3rd paragraph, the 2nd sentence was removed.	Updated to reflect that pharmacies are now enrolled through MDCH/CHAMPS, not through the PBM.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Dental	1.1.A. Early and Periodic Screening, Diagnosis and Treatment	The 2nd sentence was revised to read: The oral cavity must be inspected by the Primary Care Physician (PCP) at each well child visit to assess the need for referral to a dentist for diagnosis and treatment.	Clarification.
Family Planning Clinics	Section 3 - Laboratory	The 4th paragraph was deleted.	Information is obsolete per bulletin MSA 12-58.
Federally Qualified Health Centers	Section 1 - General Information	The 3rd paragraph was revised to read: Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 makes provision for the reimbursement of FQHCs under a prospective payment system (PPS). Section 702 of BIPA created a new section 1902(bb) in the Social Security Act. This PPS applies to …	Correction.
Federally Qualified Health Centers	Section 1 - General Information	The 4th paragraph was revised to read: States may elect to reimburse FQHCs under the PPS methodology outlined in the Act or they may choose to implement an alternative payment methodology that is agreed to by the FQHC and the state. If an alternative methodology is implemented, it must result in payment at least equal to that which an FQHC would receive under the PPS.	Clarification.
Federally Qualified Health Centers	1.1 Memorandum of Agreement for Reimbursement	In the 1st paragraph, the last sentence was revised to read: The MOA provides reimbursement at least equal to that which the FQHC would have received under the PPS required under federal regulation. The 2nd paragraph was revised to read: The MOA is effective when both MDCH and an FQHC are signatories to the document. CMS, rather than the State, is the final arbiter of the permissibility of this agreement. The signed agreement supersedes …	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Federally Qualified Health Centers	Section 4 – Billing	The 5th paragraph was revised to read: **NOTE:** If the rendering provider field is left blank, the information in the billing provider field is used as the rendering provider which may result in improper edits, rejection of the claim, or inaccurate settlements.	Clarification
Federally Qualified Health Centers	5.3 Reconciliation of Quarterly Advances	In the 2nd paragraph, the last sentence was revised to read: The FQHC may request a change in the quarterly payment through the MDCH HCRD.	Use of acronym.
Federally Qualified Health Centers	5.5 Prospective Payment Rate	The 2nd sentence was revised to read: In accordance with section 1902(bb) of the Social Security Act, the PPS per visit payment is equal to 100 percent of the average of the FQHC reasonable costs of providing Medicaid services during Fiscal Years 1999 and 2000.	Updated federal regulation citation to reflect the SSA.
Federally Qualified Health Centers	5.6 Prospective Payment Rate for New FQHC Sites	In the 2nd paragraph, the 1st sentence was revised to read: In subsequent years, the newly established FQHC shall be paid using the PPS methodology or an alternate payment methodology.	Correction.
Federally Qualified Health Centers	5.9 Alternative Payment Methodology	The following text was added at the end of the paragraph: CMS, rather than the State, is the final arbiter of the permissibility of this agreement.	Update.
Home Health	Section 10 – Durable Medical Equipment (DME)/Supplies	In the last (4th) paragraph, the following text was inserted as the 2nd sentence: If the quantity needed is beyond what is listed on the Home Health Database, the supplies must be billed by a DME/Medical Supplier.	Clarification.
Hospital Reimbursement Appendix	1.5 Payment Calculation	The 2nd paragraph was revised to read: The MDCH payment is the lesser of: • the Medicaid fee screen/allowable amount, minus any Medicare or other insurance payments, and any applicable Medicaid copayment, patient-pay, and/or deductible; or	Edit of text removed in error.

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		• (for fee schedule items) the provider's charge, reduced by any contractual adjustments, minus any Medicare or other insurance payments, and any applicable Medicaid copayment, patient-pay, or deductible amount; or • the beneficiary's liability for coinsurance, copayments, and/or deductibles.	
Hospital Reimbursement Appendix	7.3.A. Government Provider DSH Pool	In the 1st paragraph, the 3rd sentence was revised to read: A historical list of Government Provider pool sizes is maintained on the MDCH website. (Refer to the Directory Appendix for website information.)	Update.
Hospital Reimbursement Appendix	7.3.B. Indigent Care Agreements Pool	In the 1st paragraph, the 5th sentence was revised to read: A historical list of ICA pool sizes is maintained on the MDCH website. (Refer to the Directory Appendix for website information.)	Update.
Hospital Reimbursement Appendix	7.4 Calculation of DSH Ceiling	In the 1st paragraph: 1. The heading "1. Base Year Data" was revised to read "1. DSH Ceiling Financial Elements." 2. In the 4th bullet point, the 3rd sentence was deleted ("Hospitals may designate the appropriate ratio for this calculation as either the Title XIX cost to charge ratio or the overall hospital cost to charge ratio.")	Update; clarification.
Hospital Reimbursement Appendix	7.4 Calculation of DSH Ceiling	In the 1st paragraph , the heading "2. Adjustments to Base Year Data" and the two bullet points directly below were deleted. In the 2nd paragraph, the 2nd line of the calculation was revised to read: Uninsured charges x uninsured cost to charge ratio = uninsured costs	Clarification; removal of repetitive information.

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		The 3rd paragraph was revised to read: The following trend factors will be applied to the financial elements used to calculate hospital DSH ceilings only during the Initial DSH Calculation for each year. These trend factors will not be applied during the Interim DSH Settlement calculations. The 5th paragraph was deleted ("The ceiling is then: CY Title XIX Costs + CY uninsured costs – total CY payments = CY DSH Ceiling.").	
Hospital Reimbursement Appendix	7.5 Disproportionate Share Hospital (DSH) Process	Under "Step 2: Interim DSH Settlement", 1st paragraph, the 2nd sentence was revised to read: This may result in DSH recoveries for some hospitals during this step.	Clarification.
Maternity Outpatient Medical Services Program	1.1 Eligibility Determination	In the 1st paragraph, the 1st bullet point was revised to read: • Income at or below 195 percent of the Federal Poverty Level.	Update.
Mental Health/ Substance Abuse	1.4 Provider Registry	In the 1st paragraph, the 2nd sentence was revised to read: ...and the Bureau of Community Based Services for	Due to internal name change after re-organization.
Mental Health/ Substance Abuse	12.2.F. Discontinuation/ Termination Criteria	In the 1st paragraph, 4th bullet point, the 2nd sentence was revised to read: The beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS) has a right to appeal this decision. Services must continue and dosage levels maintained while the appeal is in process, unless the action is being carried out due to administrative discontinuation criteria outlined in the subsection titled Administrative Discontinuation.	Clarifies the purpose of administrative discontinuation and supports the immediate termination as outlined in the referenced section.
Nursing Facility Coverages	5.1.D.2. Nursing Facility Level of Care Exception Process	The 1st sentence was revised to read: The Nursing Facility Level of Care (LOC) Exception Review is available for Medicaid financially pending or Medicaid financially eligible beneficiaries who do not meet medical/functional eligibility based on a valid online Michigan Medicaid Nursing Facility LOC Determination (LOCD), but demonstrate a significant level of long term care need.	The LOCD must be a valid LOCD conducted within policy guidelines and timeframes for all providers for whom the LOCD is applicable.

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CHAPTER	SECTION	CHANGE	COMMENT
		The 3rd sentence was revised to read: The Nursing Facility LOC Exception Review may be initiated only when the provider telephones the MDCH designee on the date the provider conducted a valid online LOCD and requests the LOC Exception Review on behalf of the LOCD ineligible beneficiary.	
Nursing Facility Coverages	10.37.A. Non-emergency Transportation	The subsection title was revised to read: Non-emergency Non-ambulance Transportation In the 1st paragraph, the 1st and 2nd sentences were revised to read: The nursing facility is responsible for non-emergency non-ambulance transportation for all Medicaid beneficiaries, including Medicare/Medicaid beneficiaries when Medicare is covering the cost of the care. This transportation includes … And the 4th sentence was revised to read: Reimbursement for non-emergency non-ambulance transportation, whether …	Clarification.
Pharmacy	1.1 MDCH Pharmacy Benefits Manager and Other Vendor Contractors	In the 1st paragraph, the 2nd sentence was revised to read: … retrospective drug utilization, clinical consultation, provider information lines, and …	Updated to reflect that pharmacies are now enrolled through MDCH/CHAMPS, not through the PBM.
Pharmacy	3.2 Enrollment	Subsection text was revised to read: Pharmacy enrollment is processed through CHAMPS. Refer to the General Information for Providers Chapter, Provider Enrollment section, for additional information.	Updated to reflect that pharmacies are now enrolled through MDCH/CHAMPS, not through the PBM.

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CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	13.6.A. Medicaid Copayments	The 1st paragraph was revised to read: A $1 copayment for each generic/preferred drug dispensed, and a $3 copayment for each brand name/non-preferred drug dispensed, may apply for Medicaid beneficiaries age 21 years and older.	A $1 copayment may also apply to *preferred* brand name products that are more cost effective and 'preferred' on the Department's Preferred Drug List. A $3 copayment may apply to *non-preferred* generic products that are less cost effective and identified as 'non-preferred' on the Department's Preferred Drug List.
Practitioner	4.14.B. Referred Services	The 3rd paragraph was revised to read: A beneficiary cannot be charged for any covered laboratory procedure, including those that are determined to be not medically necessary. The 4th paragraph was deleted.	Information obsoleted by bulletin MSA 12-58.
Practitioner	4.14.C. Laboratory Tests Exempt from Daily Limit	Subsection was deleted. Following subsection was re-numbered.	Information obsoleted by bulletin MSA 12-58.
Practitioner	15.2 Substance Abuse Services	In the chart, under "Acute Care Detoxification": 1. The first bullet point was re-formatted to read as two bullet points: • Vital signs, extreme and unstable • Uncontrolled hypertension, extreme and unstable 2. The last bullet point was revised to read: • Active presentation of psychotic symptoms reflecting an emergent/urgent condition.	Corrections.
Rural Health Clinics	1.2 General Reimbursement Information	Text was revised to read: Medicaid-enrolled RHCs are reimbursed with a prospective payment system (PPS) in compliance with Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Section 702 of BIPA created a new section 1902(bb) in the Social Security Act. Specific information related to ...	Updated federal regulation citation to reflect the SSA.

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CHAPTER	SECTION	CHANGE	COMMENT
Rural Health Clinics	4.2 Eligibility Groups Subject to PPS Methodology	Within the Medicaid Health Plan Enrollees portion of the chart, the 3rd bullet point was revised to read: • The RHC must file information with the MDCH HCRD in a format …	Use of acronym.
Rural Health Clinics	Section 5 – Rate Setting	In the 1st paragraph, the 2nd sentence was revised to read: In accordance with section 1902(bb) of the Social Security Act, the PPS per visit payment is equal to 100 percent of the average of the RHC's reasonable costs of providing Medicaid services during fiscal years 1999 and 2000.	Update.
Rural Health Clinics	6.1 Billing Rural Health Clinic Services	The 5th paragraph was revised to read: … the information in the billing provider field is used as the rendering provider which may result in improper edits, rejection of the claim, or inaccurate settlements.	Clarification
Tribal Health Centers	Section 1 – General Information	In the 4th paragraph, 3rd bullet point, the 2nd sentence was revised to read: In this event, reimbursement to the THC defaults to the payment methodology described under section 1902(bb) of the Social Security Act.	Updated federal regulation citation to reflect the SSA.
Tribal Health Centers	3.1 Covered Services	In the 3rd paragraph, under Pharmacy Services, the 2nd sentence was deleted from the 3rd paragraph.	Updated to reflect that pharmacies are now enrolled through MDCH/CHAMPS, not through the PBM.
Tribal Health Centers	Section 6 – Encounters	In the 2nd paragraph, the 2nd sentence was revised to read: The FQHC encounter rate under the FQHC MOA is an alternative methodology that was based on the prospective payment system (PPS) outlined in section 1902(bb) of the Social Security Act.	Updated federal regulation citation to reflect the SSA.
Acronym Appendix	BIPA	The following text was added to the definition: Section 702 of BIPA created a new section 1902(bb) in the Social Security Act.	Updated federal regulation citation to reflect the SSA.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Provider Assistance	Information for "MDCH PBM Pharmacy Enrollment" was removed.	Obsolete information (pharmacies are now enrolled through MDCH/CHAMPS, not through the PBM).
Directory Appendix	Beneficiary Assistance	Addition of: **Contact/Topic:** Medicare Buy-In Unit **Phone # Fax #:** 517-335-5488; Fax 517-335-0478 **Mailing/E-Mail/Web Address:** MDCH/Buy-In Unit Lewis Cass Bldg. 320 S. Walnut St. Lansing, MI 48913 BuyInUnit@michigan.gov **Information Available/Purpose:** Reviews Medicare/Medicaid dual eligible beneficiary information to determine if they qualify for the Medicare Buy-In/Medicare Savings Program.	Information relocated from "Claim Submission/Payment."
Directory Appendix	Claim Submission/ Payment	Information for the "Medicare Buy-In Unit" was removed.	Information was relocated to the Beneficiary Assistance section.
Directory Appendix	Appeals	Under "Appeals (Beneficiary)", "Information Available/Purpose" was revised to read: Beneficiaries may request a hearing on an action to discontinue, terminate, suspend, or reduce public assistance or services. A hearing may also be requested on an action to deny a choice of provider assignment in the Benefits Monitoring Program (BMP).	Clarification.
Directory Appendix	Provider Resources	Under "Reimbursement & Audit", the following website information was added: www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Inpatient Hospitals	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Mental Health/ Substance Abuse Resources	Under "Children's Waiver Program": • Addition of phone number: 517-241-5757 • 2nd and 3rd lines of mailing address revised to read "MDCH-BHDDA/Division of Quality Management & Planning" Under "PIHP Provider Registry": • 1st and 2nd lines of mailing address revised to read "MDCH-BHDDA /Division of Program Development, Consultation & Contracts" Under "PIHP Special Program Approval": • phone number was revised to read "517-335-0499" • 1st and 2nd lines of the mailing address revised to read "MDCH-BHDDA/ Community Practices and Innovation Section/Division of Quality Management & Planning"	Updates.
Directory Appendix	Pharmacy Resources	Information for "MDCH PBM Pharmacy Enrollment" was revised to read: Contact/Topic: MDCH Pharmacy Benefit Manager (PBM) Mailing Address: Magellan Medicaid Administration, Inc. Michigan Medicaid – Pharmacy Provider Relations Unit 4300 Cox Rd. Glenn Allen, VA 23060 Information Available/Purpose: Pharmacy remittance advice, EFT requests, and other services/inquiries	Pharmacy providers are enrolled with all other MDCH providers in the CHAMPS system. The PBM Pharmacy Provider Relations Unit continues to handle Remittance Advice, EFT requests and other related inquiries/services for pharmacy providers.

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Directory Appendix	Other Health Care Resources/Programs	Under "Children's Waiver Program": • 1st and 2nd lines of mailing address revised to read "MDCH-BHDDA/Division of Quality Management & Planning" Under "Habilitation Supports Waiver for Persons with Developmental Disabilities": • phone number revised to read "517-335-4419" • 1st and 2nd lines of mailing address revised to read "MDCH-BHDDA/Division of Quality Management & Planning" Under "Mental Health Home-based Program": • 2nd line of mailing address was revised to read "BHDDA"	Updates.
Forms Appendix	Sample 4 – Paper Remittance Advice	In the first section of the "sample" page, "Warrant/ETF #: ...." was revised to read "Warrant/EFT #: ....".	Correction.
Forms Appendix	DCH-0893	• Addition of fields for Prescribing Provider Information • Clarification of instructions	Updates.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 13-41	10/1/2013	Children's Special Health Care Services	9.1 Specialty Dental Benefits	In the 1st paragraph, the 2nd sentence was revised to read: Services include, but are not limited to, dental implants, orthodontia, and specialty crown and bridge.
		Dental	8.2.C. Implant Services (new subsection; following subsection re-numbered)	New subsection text reads: Dental implants, surgical guides and occlusal guards are covered for CSHCS beneficiaries who have a qualifying diagnosis of anodontia or traumatic injury to the dental arches, and standard restorative treatment is contraindicated. Dental implants require prior authorization and must be approved before the initiation of treatment. Submission of the following information is required: • Complete medical history • Complete dental history • Diagnoses • Treatment plan • Panoramic x-ray • Medical justification for the implant services, including the reason alternative forms of prosthetics would not restore function effectively Providers performing dental implant and adjunctive services must have specialized training in implant procedures (e.g., licensed oral-maxillofacial surgeons or periodontists). Providers must be approved by CSHCS and authorized on the individual CSHCS client's authorized provider file to receive reimbursement. (Refer to the Children's Special Health Care Services chapter for CSHCS provider approval/authorization information).

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Adjunctive services, including surgical stents, surgical splints and occlusal guards, are covered only when necessary for the success of implant services. Adjunctive services require prior authorization and must include a reason why the services are necessary. Procedure codes and descriptions for surgical implants, custom or prefabricated abutments, implant supported crowns, occlusal guards and specialized prosthetics are found within the American Dental Association's Current Dental Terminology (CDT) Manual. Information regarding procedure codes is maintained in the Dental Database and the Oral/Maxillofacial Surgeon Database which are available on the MDCH website. When billing for implant procedures, the date of service is the date of completion. Note: CSHCS coverage ends at age 21. The client cannot be billed for services completed after CSHCS eligibility ends.
MSA 13-34	8/30/2013	Billing & Reimbursement for Institutional Providers	6.5 Telemedicine	The 2nd sentence was revised to read: Refer to the Telemedicine Section of the Practitioner Chapter for additional information.
			7.27 Telemedicine	Text was revised to read: To be reimbursed for the originating site facility fee, the hospital must bill the appropriate telemedicine CPT/HCPCS procedure code and modifier. Refer to the Telemedicine Section of the Practitioner Chapter for additional information. Procedure code and modifier information …
			8.14 Other Service Revenue Codes	The 3rd bullet point was revised to read: Telemedicine – To be reimbursed for the originating site facility fee, the NF must bill the appropriate telemedicine NUBC revenue code with the appropriate telemedicine procedure code and modifier. Refer to the Telemedicine Section of the Practitioner Chapter for additional information. Procedure code and modifier information is …

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Billing & Reimbursement for Professionals	6.22 Telemedicine	The 1st sentence was revised to read: Procedure code and modifier information is contained in the MDCH Telemedicine Services Database available on the MDCH website.
			6.22.A. Originating Site	The following text was added as the 1st sentence: To be reimbursed for the originating site facility fee, the originating site provider must bill the appropriate telemedicine procedure code and modifier.
			6.22.B. Distant Site	Subsection text was revised to read: The modifier for interactive communication must be used in conjunction with the appropriate HCPCS procedure code to identify the professional telemedicine services provided by the distant site provider. To be reimbursed for services that are telemedicine specific (that can only be billed via telemedicine), the provider must use the interactive communication modifier. If the appropriate modifier is not supplied, the service cannot be paid.
		Children's Special Health Care Services	Section 9 - Benefits	The following bullet point was added: • Telemedicine
			9.8 Telemedicine	The subsection was deleted. (Information is found in Section 9 – Benefits.)
		Federally Qualified Health Centers	2.3 Telemedicine	Subsection text was revised to read: An FQHC can be either an originating or distant site for telemedicine services. Refer to the Billing & Reimbursement for Professionals Chapter for specific billing instructions. Refer to the Telemedicine Section of the Practitioner Chapter for additional information regarding telemedicine services.

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				Procedure code and modifier information is contained in the MDCH Telemedicine Services Database available on the MDCH website. (Refer to the Directory Appendix for website information.)
		Hospital	3.33 Telemedicine	Subsection text was revised to read: A hospital can be either an originating or distant site for telemedicine services. Refer to the Billing & Reimbursement for Institutional Providers Chapter for specific billing instructions. Refer to the Telemedicine Section of the Practitioner Chapter for additional information regarding telemedicine services. Procedure code and modifier information is contained in the MDCH Telemedicine Services Database available on the MDCH website. (Refer to the Directory Appendix for website information.)
		Mental Health/ Substance Abuse	3.26 Telemedicine	Subsection text was revised to read: A CMH/PIHP can be either an originating or distant site for telemedicine services. Practitioners must meet the provider qualifications for the covered service provided via telemedicine. No additional reimbursement will be made for the site facility fee. Refer to the Telemedicine Section of the Practitioner Chapter for additional information regarding telemedicine services. Procedure code and modifier information is contained in the MDCH Telemedicine Services Database available on the MDCH website. (Refer to the Directory Appendix for website information.)
		Nursing Facility Coverages	10.35 Telemedicine	Subsection text was revised to read: A nursing facility can be either an originating or distant site for telemedicine. Refer to the Billing & Reimbursement for Institutional Providers Chapter for information regarding billing the originating site facility fee. Refer to the Telemedicine Section of the Practitioner Chapter for additional information regarding telemedicine services.

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				Procedure code and modifier information is contained in the MDCH Telemedicine Services Database available on the MDCH website. (Refer to the Directory Appendix for website information.)
		Practitioner	Section 20 – Telemedicine	Subsection text was revised to read: Telemedicine is the use of telecommunication technology to connect a patient with a health care professional in a different location. MDCH requires a real time interactive system at both the originating and distant site allowing instantaneous interaction between the patient and health care professional via the telecommunication system. Telemedicine should be used primarily when travel is prohibitive for the beneficiary or there is an imminent health risk justifying immediate medical need for services. Providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine. The technology used must meet the needs for audio and visual compliance in accordance with current regulations and industry standards. Telecommunication systems using store and forward technology, including asynchronous transmission of medical data or the use of robotics for remote access surgical procedures, are not included in this policy.
			20.1 Telemedicine Services	Subsection text was revised to read: The following services may be provided via telemedicine: • ESRD-related services • Behavior change intervention • Behavior Health and/or Substance Abuse Treatment • Education Services, Telehealth • Inpatient consultations • Nursing facility subsequent care

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				• Office or other outpatient consultations • Office or other outpatient services • Psychiatric diagnostic procedures • Subsequent hospital care • Training service – Diabetes Where face-to-face visits are required (such as ESRD and nursing facility related services), the telemedicine service may be used in addition to the required face-to-face visit, but cannot be used as a substitute. There must be at least one face-to-face hands-on visit (i.e., not via telemedicine) by a physician, nurse practitioner, or physician's assistant per month to examine the vascular site for ESRD services. The initial visit for nursing facility services must be face-to-face. Procedure code and modifier information is contained in the MDCH Telemedicine Services Database available on the MDCH website. (Refer to the Directory Appendix for website information.)
			20.3 Authorized Originating Site	In the 2nd paragraph, the 5th bullet point was revised to read: • Hospital-based or CAH-based Renal Dialysis Centers (including satellites) The 3rd paragraph was revised/reformatted to read: Information regarding billing for the originating site facility fee is contained in the Billing & Reimbursement for Institutional Providers and the Billing & Reimbursement for Professionals chapters. Providers at the originating site may bill services they provide on the same date as a service that is performed via telemedicine. The originating site provider is not limited to services listed on the Telemedicine Services database but must bill the medically necessary service they performed.
			20.4 Distant Site	Text after the 2nd sentence was revised to read: Providers at the distant site can only bill services listed in the Telemedicine Services database.

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			20.5 Authorized Practitioners	Subsection text was revised to read: The following health professionals may provide telemedicine services: • Physician (MD, DO, DPM) • Nurse Practitioner (NP) • Nurse Midwife • Physician's Assistant • Clinical Nurse Specialist (CNS)** • Clinical Psychologist ** • Clinical Social Worker ** ** Clinical Nurse Specialists, Psychologists and Social Workers cannot bill MDCH directly. Services must be provided through a Prepaid Inpatient Health Plan (PIHP)/CMHSP, FQHC, or THC. Psychotherapy services that include medical evaluation and management services cannot be provided by Psychologists or Social Workers. If providing services through the PIHP/CMHSP or County Health Plan (CHP), the provider must have a contract with or be authorized by the appropriate entity. In order to be reimbursed for services, distant site providers must be enrolled in MI Medicaid. When providing services via telemedicine, providers can only bill for services listed on the Telemedicine Services database. Procedure code and modifier information is contained in the MDCH Telemedicine Services Database available on the MDCH website. (Refer to the Directory Appendix for website information.)
		Rural Health Clinics	3.3 Telemedicine	Subsection text was revised to read: An RHC can be either an originating or distant site for telemedicine services. Refer to the Billing & Reimbursement for Institutional Providers Chapter for specific billing instructions. Refer to the Telemedicine Section of the Practitioner Chapter for additional information regarding telemedicine services.

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				Procedure code and modifier information is contained in the MDCH Telemedicine Services Database available on the MDCH website. (Refer to the Directory Appendix for website information.)
		Tribal Health Centers	3.1 Covered Services	In the 3rd paragraph, under "Telemedicine", text was revised to read: A THC can be either an originating or distant site for telemedicine services. Refer to the Billing & Reimbursement for Institutional Providers Chapter for specific billing instructions. Refer to the Telemedicine Section of the Practitioner Chapter for additional information regarding telemedicine services. Procedure code and modifier information is contained in the MDCH Telemedicine Services Database available on the MDCH website. (Refer to the Directory Appendix for website information.)
MSA 13-39	8/29/2013	General Information for Providers	1.1 Bulletins	The 2nd paragraph was revised to read: Bulletins are distributed to affected providers by U.S. Mail or e-mail. Providers are encouraged to maintain current contact information in CHAMPS for timely notification. Bulletins are also posted on the MDCH website. (Refer to the Directory Appendix for website and contact information.)
			Section 3 - Maintenance of Provider Information	In the 2nd paragraph, the following bullet point was added: • E-mail address In the 3rd paragraph, the yellow burst box was revised to read: The Provider Enrollment Unit disenrolls providers if postal mail is returned as nondeliverable.
MSA 13-37	8/29/2013	Billing & Reimbursement for Institutional Providers	10.1 Direct Billing to MDCH	The 1st sentence was revised to read: Providers must bill MDCH directly (either paper or electronically) using the codes listed in the MDCH Private Duty Nursing Reimbursement Rates Database posted on the MDCH website.

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				In the chart, 2nd line, the 1st column was revised to read "Units." In the chart, under "Billable Units", the description was revised to read: PDN services are authorized, billed, and paid in 15-minute incremental units. The total number of units reported on the claim must not exceed the total units that were authorized for that month. Since 15 minute units of care are authorized, only those units of care that entail a full 15 minutes of care may be billed. In the chart, under "Multiple Beneficiaries Seen at Same Location", the 1st paragraph of the description was revised to read: The total Medicaid reimbursement for multiple beneficiaries is time-and-one-half for two beneficiaries. The specific codes listed in the HCPCS Codes/Modifiers section of the MDCH Private Duty Nursing Reimbursement Rates Database must be used if an RN or LPN is caring for more than one beneficiary at the same location for which this approach to staffing has been authorized. These codes must be used for each beneficiary provided care (i.e., first, second beneficiary). For example, if there is one RN caring for two children at the same location, as approved, the multiple modifier code must be used for both children.
			10.1.A. Revenue Codes/ HCPCS Codes/Modifiers	Subsection text was revised to read: When billing, the provider must use the appropriate codes. HCPCS codes/modifiers are located in the Healthcare Common Procedure Coding System manual. The Private Duty Nursing Reimbursement Rates Database, posted on the MDCH website, outlines private duty nursing rates and applicable codes. (Refer to the Directory Appendix for website information.)
			10.1.B. Payment in One Hour Increments	The subsection was renamed as "Payment in 15-Minute Increments." Subsection text was revised to read: Private duty nursing is prior authorized and paid in 15-minute incremental units. When billing for services, the total number of units billed must not exceed the total number of units authorized for that month. Since 15-minute increments of care are authorized, only those units of care that entail a full 15 minutes of care may be billed.

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		Billing & Reimbursement for Professionals	6.17.A. Direct Billing to MDCH	The 1st sentence was revised to read: Providers must bill MDCH directly (either paper or electronically) using the codes listed in... In the chart, 3rd row, the 1st column was revised to read "Units." In the chart, under "Billable Units", the description was revised to read: PDN services are authorized, billed, and paid in 15-minute incremental units. The total number of units reported on the claim must not exceed the total units that were authorized for that month. Since 15 minute units of care are authorized, only those units of care that entail a full 15 minutes of care may be billed. In the chart, under "Multiple Beneficiaries Seen at Same Location", the 1st paragraph of the description was revised to read: The appropriate code must be used if an RN or LPN is caring for more than one beneficiary at the same location for which this approach to staffing has been authorized. This code must be used for each beneficiary provided care (i.e., first, second beneficiary). For example, if there is one RN caring for two children at the same location, the multiple beneficiary modifier code must be used for both children.
			6.17.B. HCPCS Codes/Modifiers	Subsection text was revised to read: When billing, the provider must use the appropriate codes. HCPCS codes/modifiers are located in the Healthcare Common Procedure Coding System manual. The Private Duty Nursing Reimbursement Rates Database, posted on the MDCH website, outlines private duty nursing rates and applicable codes. (Refer to the Directory Appendix for website information.)

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			6.17.C. Payment in One-Hour Increments	The subsection was renamed as "Payment in 15-Minute Increments." Subsection text was revised to read: Private duty nursing is prior authorized and paid in 15-minute incremental units. When billing for services, the total number of units billed must not exceed the total number of units authorized for that month. Since 15-minute increments of care are authorized, only those units of care that entail a full 15 minutes of care may be billed.
			7.10 Private Duty Nursing	Under "Special Instructions", text was revised to read: Use this modifier with HCPCS code T1000 and either modifier TD for RN or TE for LPN when private duty nursing services are being provided to more than one beneficiary at one time.
		Private Duty Nursing	1.4 Prior Authorization	In the 1st paragraph, the following text was inserted after the 2nd sentence: PDN services are authorized and billed in 15-minute incremental units (1 unit = 15 minutes). In the 6th paragraph, references to "hours" were revised to read "units."
			1.7 Benefit Limitations	In the 1st paragraph, text after the 3rd sentence was revised to read: The calculation of the number of units authorized per month includes eight hours or more of care that will be provided by the caregiver during a 24-hour period, which are then averaged across the time authorized for the month. The caregiver has the flexibility to use the monthly-authorized units as needed during the month.
			1.8 Service Log	In the chart in the 2nd paragraph, the title for the 5th column was revised to read "Units" and information in rows 2 through 5 for the 5th column was revised to read "16", "33", "21" and "23."
			1.9 Clinical Record	The 2nd sentence was revised to read: ... and billed to Medicaid in 15-minute incremental units.

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			2.4 Determining Intensity of Care and Maximum Amount of PDN	In the 3rd paragraph, text after the 1st sentence was revised to read: The Decision Guide is used to determine the appropriate range of nursing hours (prior authorized and billed in 15-minute increments) that can be authorized under the Medicaid PDN benefit and defines the "benefit limitation" for individual beneficiaries. The Decision Guide is used by the authorizing entity after it has determined the beneficiary meets both general eligibility requirements and medical criteria as stated above. The amount of PDN (i.e., the time) that can be authorized for a beneficiary is based on several factors, including the beneficiary's care needs which establish medical necessity for PDN, the beneficiary's and family's circumstances, and other resources for daily care (e.g., private health insurance, trusts, bequests, private pay).
		Forms Appendix	MSA-0732	Instructions were revised to reflect the change in 'units' and modifier use.
MSA 13-36	8/29/2013	Billing & Reimbursement for Professionals	7.12 School Based Services	Addition of: Modifier: TL Description: Reevaluation of Existing Data (REED) Special Instructions: Use this modifier with the appropriate procedure codes to identify when a reevaluation of existing data (REED) was used in the determination of the child's eligibility for special education services.
MSA 13-31	8/29/2013	Outpatient Therapy	1.1 Service Provision	Under the 1st bullet point, the following sub-bullet point was added: ➢ Optometrist's Office
		Vision	3.6.C. Replacement and Supplies	The 4th paragraph was revised to read: Requests for contact lens replacements due to loss or damage will require PA and will be reviewed on an individual basis.

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			3.8 Orthoptics and/or Pleoptics Training	Under "Orthoptics and Pleoptics Training", the 1st paragraph was revised to read: Orthoptics and Pleoptics (O & P) training is a Medicaid benefit only when there is a diagnosis of one of the following conditions: • Amblyopia • Esotropia • Exotropia • Heterotropia • Strabismus • Ocular Motor and Fusion Dysfunction PA is not required for O & P training for beneficiaries under age 21. PA is required for beneficiaries age 21 and older for O & P training. The following text was inserted after the 3rd paragraph: O & P training is limited to a maximum of 13 visits within the first three calendar months of therapy without PA. PA will be required for additional necessary visits.
MSA 13-32	8/26/2013	Coordination of Benefits	3.2 Hospital Credit Balance Refund Process (new subsection; following subsections were re-numbered)	New subsection text reads as follows: A TPL hospital credit balance refers to funds that must be returned to MDCH because a claim has been paid by another resource or paid incorrectly. Providers must refund credit balance overpayments by submitting claim adjustments or claim voids through CHAMPS or submitting them via an electronic claim vendor. Providers are required to include a comment on the claim adjustment or claim void that reads "Credit Balance MM/DD/YYYY" where MM/DD/YYYY is the date the overpayment was identified.

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				Providers are required to resolve credit balances before submitting their fiscal year end cost report. Any credit balances adjusted through CHAMPS prior to the MDCH designated contractor's audit need not be reported to the contractor. For credit balance adjustments performed via CHAMPS, the provider's documentation must match the identification date noted in the claim adjustment or claim void comments within CHAMPS.
MSA 13-30	8/23/2013	Dental	9.1 Coverage and Service Area Information	In the 1st paragraph, the 1st sentence was revised to read "... in 78 counties." In the 2nd paragraph, the following counties were added to the list: Ingham (33), Ottawa (70) and Washtenaw (82)
MSA 13-29	8/23/2013	Home Health	7.3 Speech-Language Therapy	In the 4th paragraph, bullet points were revised to read: • A licensed speech-language pathologist (SLP). • ... completed all requirements but has not obtained a license. All documentation ... • ... (i.e., in the presence of) a licensed SLP. All documentation ...
		Mental Health/ Substance Abuse	2.4 Staff Provider Qualifications	In the chart in the 2nd paragraph, the information for "Speech Pathologist" was revised to read: Speech-Language Pathologist (SLP): An individual engaged in the practice of Speech-Language Pathology and is licensed by the State of Michigan to provide such services.
			3.23 Speech, Hearing and Language	Under Evaluation, text was revised to read: Activities provided by a licensed speech-language pathologist or ... Under Therapy, the 3rd paragraph was revised to read: ... and education of a licensed speech-language pathologist) ...

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				The 4th paragraph was revised to read: Services may be provided by a licensed speech-language pathologist ... ... and signed by the appropriately licensed supervising speech-language pathologist or audiologist.
		Nursing Facility Coverages	10.36.C. Speech Pathology/ Therapy (ST)	The 1st paragraph was revised to read: The services must be for active, restorative treatment and must be rendered by a licensed speech pathologist. For speech pathology evaluations, a copy of the speech pathologist's license must accompany the first prior authorization request for that pathologist.
		Outpatient Therapy	5.3 Speech Therapy	In the 2nd paragraph, the bullet points were revised to read: • A speech-language pathologist (SLP) with a current license. • ... completed all requirements but has not obtained a license. All documentation ... • ... (i.e., in the presence of) an SLP having a current license. All documentation ... In the 7th paragraph, the 1st sentence was revised to read: ... knowledge and education of a licensed SLP to assess ...
		Practitioner	19.2 Coverage Conditions	In the 1st paragraph, the bullet points were revised to read: • A speech-language pathologist (SLP) possessing a current license. • ... completed all requirements but has not obtained a license. All documentation ... • ... under the direct supervision of an SLP having a current license. All documentation ... In the 8th paragraph, the 1st sentence was revised to read: ... and education of a licensed speech-language pathologist to assess ...

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		School Based Services	1.6 Service Expectations	In the 1st paragraph, the 2nd sentence was revised to read: ... and education of a licensed occupational therapist, licensed physical therapist or licensed speech-language pathologist or licensed audiologist).
			2.1 Individuals with Disabilities Education Act Assessment and IEP/IFSP Development, Review and Revision	Under Provider Qualifications, the 4th bullet point was revised to read: • A licensed speech-language pathologist (SLP)
			2.4.A. Speech, Language and Hearing Therapy	Under Definition, the last sentence was revised to read: Speech, language and hearing therapy must require the skills, knowledge and education of a licensed speech-language pathologist or audiologist to provide the therapy. Under Provider Qualifications, bullet points were revised to read: • A licensed speech-language pathologist (SLP); • A licensed audiologist in Michigan; • A speech-language pathologist (SLP) and/or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a license) under the direction of a qualified SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed SLP or licensed audiologist; or • A teacher of students with speech and language impairments (TSLI) under the direction of a licensed SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed supervising SLP or licensed audiologist. Under Evaluations for Speech Pathology Services, in the 1st paragraph, the 2nd sentence was revised to read: They may be completed by a licensed SLP or audiologist.

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			2.4.B. Assistive Technology Device Services	Under Provider Qualifications, the 2nd bullet point was revised to read: • A licensed speech-language pathologist (SLP).
			2.9 Personal Care Services	Under Prescription, the 2nd sentence was revised to read: ... Master of Social Work (MSW), or licensed Speech-Language Pathologist (SLP).
		School Based Services Random Moment Time Study	3.3.B. AOP & FFS/Direct Medical Services Staff Pool	The 1st bullet point was revised to read: • Licensed Speech-Language Pathologists And the footnote (*) was removed.
		Acronym Appendix		Deletion of CCC – Certificate of Clinical Competence
MSA 13-26	8/2/2013	Federally Qualified Health Centers	2.4 Children's Health Insurance Program Services (new subsection)	New subsection text reads: Section 503 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 authorizes states to incorporate a PPS rate for reimbursement of services provided to children receiving health care services through FQHCs when covered by the Children's Health Insurance Program (CHIP). Reimbursement for eligible services must comply with the requirements of section 1902 (bb) of the Social Security Act. For beneficiaries enrolled in state CHIP-funded programs (MIChild, Healthy Kids–Expansion, and Maternity Outpatient Medical Services [MOMS]), providers must bill the program according to their existing processes. For beneficiaries enrolled in a MIChild health plan, the MDCH Hospital and Clinic Reimbursement Division (HCRD) will perform an annual reconciliation of these encounters provided by FQHCs if the following conditions are met: • The FQHC must be signatory to a contract with the respective MIChild health plan covering these CHIP services. • The contract must provide for the MIChild health plan to reimburse the FQHC at a fair market rate for similarly situated beneficiaries served by non-PPS eligible providers.

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				• The FQHC must submit an electronic document of the encounters and payments associated with these CHIP plans when requesting their annual settlement. For Healthy Kids–Expansion and MOMS beneficiaries, the HCRD will perform an annual reconciliation of these encounters provided by FQHCs. The FQHC PPS rates established for eligible CHIP services are equivalent to those applicable to Medicaid for each respective year they are in effect.
		Rural Health Clinics	3.4 Children's Health Insurance Program Services (new subsection)	New subsection text reads: Section 503 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 authorizes states to incorporate a PPS rate for reimbursement of services provided to children receiving health care services through RHCs when covered by the Children's Health Insurance Program (CHIP). Reimbursement for eligible services must comply with the requirements of section 1902 (bb) of the Social Security Act. For beneficiaries enrolled in state CHIP-funded programs (MIChild, Healthy Kids–Expansion, and Maternity Outpatient Medical Services [MOMS]), providers must bill the program according to their existing processes. For beneficiaries enrolled in a MIChild health plan, the MDCH Hospital and Clinic Reimbursement Division (HCRD) will perform an annual reconciliation of these encounters provided by RHCs if the following conditions are met: • The RHC must be signatory to a contract with the respective MIChild health plan covering these CHIP services. • The contract must provide for the MIChild health plan to reimburse the RHC at a fair market rate for similarly situated beneficiaries served by non-PPS eligible providers. • The RHC must submit an electronic document of the encounters and payments associated with these CHIP plans when requesting their annual settlement. For Healthy Kids–Expansion and MOMS beneficiaries, the HCRD will perform an annual reconciliation of these encounters provided by RHCs. The RHC PPS rates established for eligible CHIP services are equivalent to those applicable to Medicaid for each respective year they are in effect.

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			4.3 Eligibility Groups Not Subject to PPS Methodology	Subsection text was revised to read: If an individual does not have Medicaid eligibility (i.e., is eligible for the Adult Benefits Waiver [ABW] or CSHCS-Title V), the services and costs are not Medicaid RHC services. ABW, CSHCS, and Family Planning Waiver (Plan First!) may be paid FFS rates only.
MSA 13-20	6/1/2013	Hospital Reimbursement Appendix	Section 5 – Capital	In the 1st paragraph, the 2nd sentence was revised to read: CIPs are paid on a monthly schedule (12 payments per year).
			Section 6 – Medicaid Interim Payments	In the 1st paragraph, the 2nd sentence was revised to read: MIPs are paid on a monthly schedule (12 payments per year).

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