MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 14-55

Distribution: All Providers

Issued: December 1, 2014

Subject: Updates to the Medicaid Provider Manual; ICD-10 Project Update; Medicaid Code and Rate Reference; Clarification of Bulletin MSA 13-43; Document Management Portal in the Community Health Automated Medicaid Processing System (CHAMPS)

Effective: As Indicated

Programs Affected: Medicaid, Healthy Michigan Plan, 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 2015 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 2015 version of the Manual does not highlight changes made in 2014. Refer to the online version of this bulletin at www.michigan.gov/medicaidproviders >> Policy and Forms to view the attachments that 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 2015 versions of the manual will be highlighted within the text of the on-line manual.

ICD-10 Project Update

MDCH continues to offer scenario-based testing for providers to assign ICD-10 diagnosis codes to outpatient medical scenarios that apply to their practice areas. These coding exercises allow providers to assess whether their current clinical systems and procedures provide for adequate data collection to support accurate ICD-10 coding. Scenario-based testing can be accessed on the MDCH website at www.michigan.gov/5010icd10 >> ICD-10 Information >> Testing.

Providers are encouraged to continue communications with software vendors, billing agents and/or service bureaus to ensure systems and procedures will support the use of ICD-10 code sets on all Health Insurance Portability and Accountability Act (HIPAA) transactions by the compliance date of October 1, 2015. Testing of ICD-10 coded transactions remains available through Business-to-Business (B2B) testing with MDCH.

Any questions regarding ICD-10 implementation should be directed to MDCH-ICD-10@michigan.gov. Questions regarding B2B testing of ICD-10 coded transactions should be directed to MDCH-B2B-Testing@michigan.gov. Providers should continue to frequently check the MDCH website at www.michigan.gov/5010icd10 for ICD-10 updates. ICD-10 training availability is posted on the MDCH website at www.michigan.gov/medicaidproviders >>Hot Topics >> Medicaid Provider Training Sessions.

Medicaid Code and Rate Reference

MDCH has launched a new online Medicaid Code and Rate Reference tool that is accessible via the External Links menu within CHAMPS. With code search capabilities, the Medicaid Code and Rate Reference tool enables providers to query real-time information specific to coverage of services. Information includes, but is not limited to, the following:

- Age range considerations,
- Documentation requirements,
- Prior authorization and conditions that may bypass these requirements,
- Service limitations, and
- Rate information.

Beginning as early as January 2015, many of the currently posted databases may be revised to include code and rate information only. The supplemental information will be available real-time by accessing the Medicaid Code and Rate Reference tool.

To request or view upcoming training sessions, please refer to Michigan Department of Community Health website at www.michigan.gov/medicaidproviders >> Communications and Training >> Medicaid Provider Training Sessions.

Any questions should be directed to Provider Inquiry, Department of Community Health, phone toll-free 800-292-2550 or e-mail at providersupport@michigan.gov.

Clarification of Bulletin MSA 13-43

Bulletin MSA 13-43, issued November 26, 2013, clarified the MDCH Medicaid claim void process. To further clarify the process for pharmacy providers, MDCH will send a Pending Claim Void notice via mail and the Archived Documents repository within CHAMPS when it is determined that a provider did not hold another resource liable for payment after Medicaid adjudicated the claim. If the claim was lacking information about the existence of another resource, the provider must resubmit the claim in CHAMPS as an adjustment and include the proper Claim Adjustment Reason Code within 30 days of the date provided on the Pending Claim Void notice. Pharmacy providers must resubmit the claim to Magellan Medicaid Administration and include the proper Other Coverage Code. Pharmacies must also notify MDCH within 30 days of the date provided on the Pending Pharmacy Claim Void notice to report the updated claim adjudication. MDCH will automatically void the claim after the 30 days if no adjustment is made in CHAMPS from medical providers or if no notification is received from pharmacy providers. The provider will then have to bill the identified resource for the claim. It is the provider's responsibility to remediate with the primary payer prior to rebilling Medicaid for the claim.

Document Management Portal in CHAMPS

Effective December 12, 2014, the Document Management Portal (DMP) within CHAMPS must be used for all documentation submitted for electronic claims (including consent forms, predictive modeling documents and medical documentation). The EZlink portal will no longer be available. Information and tutorials on the Document Management Portal are available on the MDCH website at www.michigan.gov/medicaidproviders >> Document Management Portal.

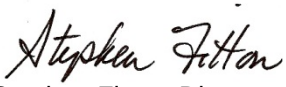
Manual Maintenance

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 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
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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Addition of: **Benefit Plan ID:** ICO-MC **Benefit Plan Name:** Integrated Care - MI Health Link **Benefit Plan Description:** This capitated managed care program is for beneficiaries who are age 21 or older and who are dually eligible for Medicare and Medicaid. The benefit plan is active only in parts of the state. The benefit includes all Medicare and Medicaid physical health services, long term supports and services, and 1915b/c waiver services for qualifying individuals. **Type:** Managed Care **Funding Source:** XIX **Covered Services (Service Type Codes):** 1, 33, 35, 42, 47, 48, 50, 54, 56, 71, 86, 88, 98, AL, UC	Updates.
Beneficiary Eligibility	2.1 Benefit Plans	In the chart in the 2nd paragraph, the Benefit Plan Description for Benefit Plan ID "HHBH" was revised to read: … other chronic physical health conditions that are amenable to care coordination and management by the health home (i.e., congestive heart failure, insulin treated diabetes, chronic obstructive pulmonary disorder, seizure disorder). …	Change in wording to reflect industry language.
Beneficiary Eligibility	2.3 Level of Care Codes	In the 1st paragraph, the following information was added to the table: LOC Code and Description: 11 – Beneficiary with Healthy Michigan Plan and enrolled in PACE Benefit Plan ID: PACE In the 3rd paragraph, the following Level of Care Codes were added to the table: • 03 – ICO-MC person meets nursing facility LOCD and lives in community • 05 – ICO-MC person resides in a nursing facility • 15 – ICO-MC person resides in a county medical care facility (CMCF)	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Dental Providers	5.1 Supernumerary Teeth	Subsection text was revised to read: Providers bill the appropriate procedure code and the supernumerary tooth number as identified using the ADA Universal/National Tooth Designation System. Supernumerary Permanent teeth are identified by the numbers 51 through 82, beginning with the upper right third molar, following the upper arch and continuing on the lower arch, concluding with the lower right third molar area in the same manner as permanent tooth numbers 1 through 32. For example, tooth number 51 would correlate with the position of tooth number 1 and tooth number 82 would correlate with the position of tooth number 32. Refer to the 2012 ADA Claim form instructions for additional information.	Clarification of supernumerary tooth numbering system and correction of resource location.
Billing & Reimbursement for Dental Providers	5.2 Loss or Change in Eligibility	The 1st and 2nd paragraphs were revised to read: Providers can only bill for root canal therapy, complete and partial dentures, and laboratory-processed crowns if loss or change in eligibility occurs. Service must have been started prior to the loss or change in eligibility. For incomplete services due to irreversible circumstances - Dentures: • When denture services have commenced, but irreversible circumstances have prevented delivery, the dentist should bill using the Not Otherwise Classified (NOC) procedure code D5899. A copy of the lab bill and an explanation in the Remarks section of the claim must be included.	Clarification
Billing & Reimbursement for Institutional Providers	7.28 Therapies (Occupational, Physical and Speech-Language)	In the 2nd paragraph, in the table,: • Under Occupational Therapy, the 1st bullet point was revised to read: o OT does not require PA for a maximum of 144 units within the first 12 consecutive calendar months of therapy. For MHP enrollees, the provider should check with the MHP for PA requirements. • Under Physical Therapy, the 1st bullet point was revised to read: o PT does not require PA for a maximum of 144 units within the first 12 consecutive calendar months of therapy.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	8.2.B. Two Facilities – Two Claims in One Month	In the 1st bullet point, the textbox was deleted. The 2nd bullet point was deleted. The 3rd bullet point was revised to read: • If the first claim has not been submitted or is suspended or rejected, and the second facility submits its claim, the whole patient-pay amount is deducted from the amount due on the second claim. The second facility needs to submit a replacement claim in order to receive its proper payment.	To conform with CHAMPS processing.
Billing & Reimbursement for Institutional Providers	8.16.A. Ventilator-Dependent Care Units	The following text was added as a 3rd paragraph: NOTE: A Level of Care Determination (LOCD) must be completed for each NPI.	Clarification.
Billing & Reimbursement for Professionals	7.8 Laboratory	For modifier "90", the following text was added to "Special Instructions": The NPI number of the reference lab must be included.	Update.
Ambulance	2.3.A. ALS 1 Nonemergency	The subsection title was revised to read: Advanced Life Support, Level 1 (ALS1) – Nonemergency Subsection text was revised to read: ALS1 is defined as the transportation by ground ambulance vehicle, and the provision of medically necessary supplies and services, which includes an ALS assessment (minimum level EMT Intermediate or Paramedic) or the furnishing of at least one ALS intervention. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Ambulance	2.3.B. ALS 1 Emergency	The subsection title was revised to read: Advanced Life Support, Emergency Transport, Level 1 (ALS1) – Emergency Subsection text was revised to read: ALS1 is defined as the transportation by ground ambulance and the provision of ALS1 services, as specified above, within the context of an emergency response.	Clarification.
Ambulance	2.3.C. ALS 2	The subsection title was revised to read: Advanced Life Support, Level 2 (ALS2) The 1st paragraph was revised to read: ALS2 is defined as the transportation by ground ambulance vehicle, and the provision of medically necessary supplies and services, including an ALS assessment, and: • the administration of at least three different medications; or • one or more of the following ALS2 procedures: ➢ Manual defibrillation/cardioversion ➢ Endotracheal intubation ➢ Central venous line ➢ Cardiac pacing ➢ Chest decompression ➢ Surgical airway ➢ Intraosseous line	Clarification.
Ambulance	2.4 Basic Life Support	The 1st paragraph was revised to read: Ambulance operations and ambulance staff must be licensed to render Basic Life Support (BLS) services by…Reimbursement for accompanying personnel, suctioning, labor/delivery, emergency first aid, …	Clarification.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Ambulance	2.4.A. BLS Nonemergency	The subsection title was revised to read: Basic Life Support (BLS) – Nonemergency Subsection text was revised to read: BLS – Nonemergency is defined as the transportation by ground ambulance and when either a BLS or an ALS provider renders BLS services as defined above.	Clarification.
Ambulance	2.4.B. BLS Emergency	The subsection title was revised to read: Basic Life Support (BLS) – Emergency Subsection text was revised to read: BLS is defined as the transportation by ground ambulance and when either a BLS or an ALS provider renders BLS services as defined above within the context of an emergency response.	Clarification.
Ambulance	2.9 Nonemergency	In the 3rd paragraph, the 1st sentence was deleted, and text after the 4th bullet point was revised to read: • Origin and destination; • Diagnosis; • Frequency of needed transports (required for ongoing, planned treatment); and • Type of ongoing treatment (required for ongoing, planned treatment). The 4th paragraph was revised to read: A separate physician's order is required for each individual transport, unless a beneficiary has a chronic medical condition that requires planned treatment. For chronic conditions, a physician may order non-emergency transportation for a maximum time period of up to 30 days in a single order. The physician's order for ongoing treatment must state the frequency of the transport and the type of ongoing treatment necessary.	Clarification.
Dental	6.1.G.1. Technical Considerations and Additional Requirements	Under "Additional Requirements", the 1st bullet point was revised to read: • All film radiographs submitted must be mounted in an x-ray mount, with the exception of a single film which may be submitted in an envelope. Only actual films or diagnostically acceptable duplicates will be accepted.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.6.A. General Instructions	The following text was added as the 6th paragraph: Complete or partial dentures are not authorized when: • A previous prosthesis has been provided within five years, whether or not the existing denture was obtained through Medicaid. • An adjustment, reline, repair, or duplication will make them serviceable. • Replacement of a complete or partial denture that has been lost or broken beyond repair is not a benefit within five years, whether or not the existing denture was obtained through Medicaid.	Return of information inadvertently removed 10/1/14
Hospice	6.6 Categories of Care	Under "General Inpatient Care", the last sentence was revised to read: Michigan Medicaid provides payment for room and board in a nursing facility if the beneficiary's hospice care would be more appropriately provided in this setting under the routine hospice benefit.	Medicaid no longer pays for room and board in a hospice residence. See MSA 14-01.
Hospital	5.5 Home and Community Based Waiver for the Elderly and Disabled (MI Choice Waiver Program)	The 1st paragraph was revised to read: The beneficiary must meet the eligibility criteria in the Michigan Medicaid Nursing Facility Level of Care Determination and require two waiver services, one of which must be Supports Coordination. Referrals are made to regional waiver providers who are responsible for screening and assessing the beneficiary for waiver eligibility. Once determined eligible, services are provided in the beneficiary's home to help the beneficiary remain as independent as possible. These services may include skilled nursing, respite care, counseling, etc. Under "Michigan Medicaid Nursing Facility Level of Care Determination", the 3rd paragraph was revised to read: While the MI Choice Waiver agent is the actual entity that must complete and submit the form, hospitals are encouraged to assess a beneficiary's functional/medical eligibility for the MI Choice Waiver using a copy of the form. A hospital may also use the Telephone Intake Guidelines to conduct an initial assessment of potential eligibility for the program. The Guidelines are also available on the MDCH website.	Updates.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.21.D. Substance Abuse Services	In the 2nd paragraph, the 7th bullet point was revised to read: Insulin treated diabetes complicated by diabetic ketoacidosis.	Change in wording to reflect industry language.
Mental Health/ Substance Abuse	3.3 Assessments	Under "Psychiatric Evaluation", 1st paragraph, the 1st sentence was revised to read: A comprehensive evaluation, performed face-to-face by a psychiatrist or psychiatric mental health nurse practitioner, that investigates a beneficiary's …	Addition of Psychiatric Mental Health Nurse Practitioner.
Mental Health/ Substance Abuse	Section 15 – Habilitation Supports Waiver for Persons with Developmental Disabilities	In the 3rd paragraph, the 3rd sentence was revised to read: Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDCH Bureau of Community Based Services.	Correction of the Bureau name.
Practitioner	15.2 Substance Abuse Services	Under "Acute Care Detoxification", the 7th bullet point was revised to read: • Insulin treated diabetes complicated by diabetic ketoacidosis	Change in wording to reflect industry language.
Practitioner	Section 17 – Occupational Therapy	Section was re-named: Outpatient Therapy Section text was revised to read: Refer to the Outpatient Therapy Chapter of this manual for additional information.	Removes duplication of information contained in the Outpatient Therapy chapter.
Practitioner	Section 18 – Physical Therapy	Section was deleted.	Removes duplication of information contained in the Outpatient Therapy chapter.
Practitioner	Section 19 – Speech and Language Therapy	Section was deleted. The following sections and subsections were re-numbered.	Removes duplication of information contained in the Outpatient Therapy chapter.

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CHAPTER	SECTION	CHANGE	COMMENT
Private Duty Nursing	Section 1 – General Information	In the 3rd paragraph, the 3rd bullet point was deleted. The following text was added as the 5th paragraph/relocated from placement as the 6th paragraph: For beneficiaries 21 and older, PDN is a waiver service that may be covered for qualifying individuals enrolled in the Habilitation Supports Waiver or MI Choice Waiver. When PDN is provided as a waiver service, the waiver agent must be billed for the services.	Updates.
Special Programs	4.1 MI Choice Waiver (Home and Community-Based Waiver for the Elderly and Disabled)	The 1st sentence was revised to read: The MI Choice Waiver provides services to aged and physically disabled individuals 18 years old and over who are eligible for full Medicaid and want to stay in their homes or …	Update.
Forms Appendix		The following forms were revised to reflect new leadership at MDCH: • MSA-1380; 835 - Electronic Remittance Advice Request for Billing Agent Change/Update • DCH-1401; Electronic Signature Agreement • DCH-1164; Guarantee of Payment Letter for Pregnancy Related Services	Update.
Forms Appendix	MSA-2565-C; Facility Admission Notice	Addition of fields: • 24: Name of MI Health Link Integrated Care Organization • 31: MI Health Link Integrated Care Organization Provider I.D. Number	DHS request to indicate the ICO in which the individual is enrolled.
Forms Appendix	DCH-0078; Request to Add, Terminate or Change Other Insurance	The website reference was revised to read: http://www.michigan.gov/reportTPL E-mail address for form submission was removed.	Update.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 14-55	12/1/2014	Coordination of Benefits	1.2 Claim Void Process	The 3rd sentence was deleted and the following text was inserted: Pharmacy providers must resubmit the claim to the Pharmacy Benefits Manager (PBM) and include the proper Other Coverage Code. Pharmacies must also notify MDCH within 30 days of the date provided on the Pending Pharmacy Claim Void notice to report the updated claim adjudication. MDCH will automatically void the claim after the 30 days if no adjustment is made in CHAMPS from medical providers or if no notification is received from pharmacy providers.
		Throughout the Manual		Information regarding databases, fee screens and fee schedules was reviewed and revised/updated as needed to reflect implementation of the Medicaid Code and Rate Reference tool.
		Throughout the Manual		Information regarding Documentation EZ-Link was reviewed and revised as needed to reflect the exclusive use of the Document Management Portal through CHAMPS as a means to upload documents supporting claims submission.
MSA 14-30	10/9/2014	Early and Periodic Screening, Diagnosis and Treatment		Addition of new chapter.
		Throughout the Manual		Information was updated as applicable to reflect the addition of the Early and Periodic Screening, Diagnosis and Treatment chapter.
MSA 14-44	10/1/14	Medical Supplier	2.3 Blood Glucose Monitoring Equipment and Supplies	Under “Standards of Coverage”, text was revised to read: A home blood glucose monitor and related supplies are covered when a beneficiary has been diagnosed with diabetes and it is medically necessary to monitor fluctuations of blood glucose levels on a daily basis. Diabetes includes: • Gestational diabetes • Insulin treated diabetes • Non-insulin treated diabetes

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				Diabetes medications (i.e., metformin, Januvia, etc.) do not qualify as insulin treatment. Quantity limits for lancets, blood glucose test strips/reagent test strips, and urine test/reagent strips/tablets are based upon insulin-treated or non-insulin-treated diabetes. Refer to the Medical Supplier database on the MDCH website for quantity and frequency information. (Refer to the Directory Appendix for website information.)
MSA 14-39 (includes MSA 14-45)	8/29/2014	Healthy Michigan Plan	3.1 Dental	In the 1st paragraph, the following text was inserted after the 1st sentence. Each health plan contracts with a dental provider group or vendor to provide dental services administered according to the contract. The contract is between the health plan and the dental provider group or vendor, and beneficiaries must receive services from a participating provider to be covered. Questions regarding eligibility, prior authorization or the provider network should be directed to the beneficiary's health plan. It is important to verify eligibility at every appointment before providing dental services. Dental services provided to an ineligible beneficiary will not be reimbursed. Text previously located in the 1st paragraph was reformatted as the 2nd paragraph.
			3.3 Hearing Aids (new subsection; following subsections re-numbered)	New subsection text reads: The Healthy Michigan Plan covers hearing aid services for all beneficiaries when provided by a licensed hearing aid dealer or licensed audiologist affiliated with a hearing center. Providers should refer to the Hearing Aid Dealers Chapter for additional guidance regarding hearing aid coverage.
			3.4 Mental Health and Substance Use Disorder Treatment Services (re-numbered)	The following text was added: Healthy Michigan Plan beneficiaries have an array of behavioral health services available to treat mental health and substance use disorders.
			3.4.A. Mental Health Services (re-numbered)	Subsection text was revised to read: Health plans will provide mental health services under the Mental Health Outpatient

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				benefit consistent with the policies and procedures established by the traditional Medicaid program. For mental health needs that do not meet established criteria or are beyond the 20-visit limitation, health plans must coordinate with the appropriate PIHP to ensure that medically necessary mental health services are provided. Refer to the Medicaid Health Plans and the Mental Health/Substance Abuse Chapters of this manual for additional information. Beneficiaries who are not enrolled in a health plan will receive their outpatient mental health services through Fee-for-Service and may include Prepaid Inpatient Health Plan services as described in this manual. Additional mental health services (e.g., inpatient hospitalization, intensive crisis stabilization, etc.) are covered benefits consistent with the policies and procedures established by the Medicaid program.
			3.4.B. Substance Use Disorder Treatment Services (re-numbered)	Subsection text was revised to read: Substance use disorder services and supports are covered by the Healthy Michigan Plan when delivered under the auspices of an approved PIHP. For Healthy Michigan Plan beneficiaries, substance use disorder services will be provided in the same manner and in coordination with the mental health services and supports. PIHPs are responsible for providing the substance use disorder benefit consistent with the policies and procedures established by the traditional Medicaid program. Eligibility for these services is based on medical necessity, individual need, and/or the type of substance being used resulting in the need for treatment. Substance use disorder service providers must also be accredited as an alcohol and/or drug abuse program. Refer to the Mental Health/Substance Abuse Chapter of this manual for additional information. All standard requirements of the Michigan Public Health Code, Article 6 – Substance Abuse apply.
			3.4.C. Behavioral Health Community-Based Services (new subsection)	New subsection text reads: The Healthy Michigan Plan covers medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service.

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				These services include the following: • Assistive Technology • Community Living Supports • Enhanced Pharmacy • Environmental Modifications • Family Support and Training • Housing Assistance • Peer-Delivered or -Operated Support Services • Prevention-Direct Service Models • Respite Care Services • Skill-Building Assistance • Supports and Services Coordination • Supported/Integrated Employment Services • Fiscal Intermediary Services Program coverage for community-based services and supports is described in the Mental Health/Substance Abuse Chapter. In compliance with Section 1915(i) of the Social Security Act, these services may be limited to individual program criteria and are based upon the following: • The services are provided in settings that meet home and community-based service setting requirements. • The services meet the person-centered service planning requirements. • Individuals receiving these services meet the state-established needs-based criteria that are not related solely to age, disability, or diagnosis, and are less stringent than criteria for entry into institutions. Services can be accessed as needed, even if the individual has needs that are below institutional level of care.

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				Additional program coverage and criteria for all mental health and substance use disorder services and supports are described in further detail in the Mental Health/Substance Abuse Chapter.
			3.5 Nursing Facility Services (new subsection)	New subsection text reads: Beneficiaries eligible for the Healthy Michigan Plan have comprehensive nursing facility coverage consistent with the policies and procedures established by the traditional Medicaid Program. This benefit is included for individuals in accordance with 42 CFR 440.315(f). Providers should refer to the Nursing Facility Chapter for additional guidance regarding nursing facility services covered for beneficiaries. Healthy Michigan Plan beneficiaries who are receiving nursing facility services in a licensed nursing facility are excluded from enrollment in a health plan. Healthy Michigan Plan beneficiaries who begin receiving nursing facility services after enrollment in a health plan may be disenrolled from the health plan under certain conditions. Providers should refer to the Medicaid Health Plans Section of the Beneficiary Eligibility Chapter for additional guidance regarding nursing facility services provided to health plan enrollees.
			3.6 Preventive Services (re-numbered)	The following text was added: It is the provider's responsibility to review these websites for current guidelines for preventive services. One preventive medicine Evaluation and Management service is covered for all adult beneficiaries annually. For beneficiaries less than 21 years of age, Early and Periodic Screening, Diagnosis and Treatment services are covered according to the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care and the Centers for Medicare & Medicaid Services requirements. In addition, the Healthy Michigan Plan covers breastfeeding equipment and supplies as a preventive service benefit. For covered equipment and supplies, refer to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

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			Section 4 – Healthy Michigan Plan and Healthy Behaviors	The following text was added: To promote the overall health and well-being of Healthy Michigan Plan beneficiaries, MDCH developed a Health Risk Assessment which, when completed, provides health plan beneficiaries the opportunity to earn incentives for actively engaging with the health care system. In addition, Healthy Michigan Plan beneficiaries are exempt from select cost-sharing requirements for services and medications that promote or maintain health.
			4.1 Initial Appointment with Primary Care Provider	The following text was added: The initial appointment may include completion of a Health Risk Assessment as described below.
			4.2 Health Risk Assessment	Content was reformatted/relocated to the following new subsections: 4.2.A. Health Risk Assessment – For Health Plan Beneficiaries 4.2.B. Health Risk Assessment – For Fee-for-Service Beneficiaries 4.2.C. Health Risk Assessment – Web-Based Training Module for Providers
			4.2.A. Health Risk Assessment – For Health Plan Beneficiaries (new subsection)	New subsection text reads: For Healthy Michigan Plan beneficiaries enrolled in a health plan, a standard Health Risk Assessment (HRA) must be completed annually. The Healthy Michigan Plan HRA (available through the health plan or the MDCH website) assesses a broad range of health issues and behaviors including, but not limited to, the following: • Physical activity • Nutrition • Alcohol, tobacco, and substance use • Mental health • Flu vaccination Beneficiaries will receive a HRA form in their Healthy Michigan Plan health plan new

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				member packet. Beneficiaries and providers may also obtain a copy of the HRA form from their health plans or online from the MDCH website. (Refer to the Directory Appendix for website information.) Beneficiaries enrolled in a health plan may complete a portion of the assessment on their own, with the assistance of MI Enrolls, or with assistance from their health plan. The final portion of the HRA must be completed in the beneficiary's primary care provider office and include provider attestations of beneficiary healthy behaviors and/or changes. Once complete, the primary care provider must give the beneficiary a copy of their HRA and securely submit a copy to the beneficiary's health plan. Each health plan has developed submission instructions, including a process for secure transmission of the HRA. All Healthy Michigan Plan health plans offer beneficiaries the opportunity to receive a reduction in cost-sharing, an incentive, or both based on submission of a completed HRA. Beneficiaries may complete more than one HRA a year, but are only eligible for one incentive per year. Attestations from primary care providers are the basis upon which eligibility for reductions in cost-sharing is based. Beneficiaries may be eligible for reductions in cost-sharing only when an HRA is completed and received by the beneficiary's health plan. • A cost-sharing reduction, incentive, or both may apply to Healthy Michigan Plan health plan beneficiaries who agree to address or maintain healthy behaviors. In addition, beneficiaries who acknowledge that changes are necessary, but who have significant physical, mental or social barriers to addressing them at the time, may also be eligible for this reduction, incentive, or both. • Healthy Michigan Plan health plan beneficiaries who do not complete a HRA, or who complete it but decline to engage in addressing health risk behaviors, are not eligible for the cost-sharing reduction or incentive. However, these individuals may become eligible if they return to the provider, complete the assessment, and agree to address one or more behavior changes, as attested to by their primary care provider.

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				All Healthy Michigan Plan health plans have an incentive for providers who complete and return the HRA form for their Healthy Michigan Plan beneficiaries. These incentives vary by health plan. Providers should contact the health plans they participate with for details regarding provider incentives and questions related to the HRA. For provider incentives related to HRAs completed for beneficiaries not yet enrolled in a health plan, refer to the Health Risk Assessment – For Fee-for-Service Beneficiaries section below.
			4.2.B. Health Risk Assessment – For Fee-for-Service Beneficiaries (new subsection)	New subsection text reads: Healthy Michigan Plan beneficiaries may receive services, including the initial primary care provider appointment and completion of the HRA, with a Fee-for-Service provider prior to enrolling in a health plan. When this occurs, the health plan and the provider are responsible for working together to ensure that the HRA is received by the health plan. Fee-for-Service providers should give each beneficiary a copy of their completed HRA at the initial appointment and forward a copy to the beneficiary's health plan after enrollment. Providers should periodically check CHAMPS for health plan enrollment information. Beneficiaries who complete the HRA during the Fee-for-Service period are eligible for the health plan cost-sharing reduction, incentive, or both upon enrollment in a health plan. The HRA incentives do not apply to beneficiaries who do not enroll in a health plan and remain in Fee-for-Service. However, these beneficiaries and their providers may choose to complete the HRA to identify health risks and opportunities for healthy behavior change. HRAs that are completed for these individuals do not need to be submitted to MDCH and can remain in the medical file. Fee-for-Service will reimburse providers for covered services provided to the beneficiary prior to the effective date of enrollment in a health plan. However, health plans are required to disburse the provider incentive for HRA forms completed during the Fee-for-Service period when the HRA form is submitted to the health plan after beneficiary enrollment. Incentives to non-network providers will be at the discretion of the health plans. Providers must utilize the date of submission of the HRA form to the

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				health plans as the date of service in order to be eligible for provider incentives.
			4.2.C. Health Risk Assessment – Web-Based Training Module for Providers (new subsection)	New subsection text reads: MDCH has a voluntary, web-based training for providers on the Healthy Michigan Plan HRA, incentives, and associated processes. (Refer to the Directory Appendix for website information.)
			Section 5 – Cost Sharing Information	Section text was revised to read: The Healthy Michigan Plan has beneficiary cost-sharing obligations. Cost-sharing includes both copays and contributions based on income, when applicable. Copayments for services may apply to Healthy Michigan Plan beneficiaries. Prior to enrollment in a health plan, beneficiaries are eligible to receive Healthy Michigan Plan services through the Fee-for-Service system where copays are collected at the point of service (with the exception of chronic conditions and preventive services, as described below). Healthy Michigan Plan beneficiaries who are exempt from cost-sharing requirements by law (e.g., individuals receiving hospice care, pregnant women receiving pregnancy-related services) are exempt from Healthy Michigan Plan cost-sharing obligations. Similarly, services that are exempt from any cost-sharing by law (e.g., preventive and family planning services) are also exempt for Healthy Michigan Plan beneficiaries. For general information on copayment requirements and exemptions, providers should refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual. Beneficiaries may not be denied care or services based on inability to pay a copayment, except as outlined in that section.
			5.3 Copay Exceptions for Services Related to Chronic Conditions (new subsection)	New subsection text reads: The Healthy Michigan Plan seeks to promote greater access to services that prevent the progression of, and complications related to, chronic diseases. A specified list of chronic conditions and related drug classes has been identified for the Healthy Michigan Plan. This applies to all Healthy Michigan Plan beneficiaries whether they are in a health plan or Fee-for-Service. When services that are generally subject to copays

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				are related to a specified chronic condition, the service will be exempt from copays. Specifically, if the beneficiary's visit is related to one of the program-specified chronic conditions and any diagnosis on the claim header (for institutional invoices) or any diagnosis on the claim line (for professional/dental invoices) reflects this chronic condition, there is no copay for the service. Providers are expected to submit claims in compliance with the International Classification of Diseases (ICD) coding guidelines and conventions. The list of chronic condition diagnosis codes and associated drug class and treatment categories subject to the copay exemption is maintained on the MDCH website. (Refer to the Directory Appendix for website information.)
			5.4 Copay Exceptions Related to Preventive Services (new subsection)	New subsection text reads: For all Healthy Michigan Plan beneficiaries, both Fee-for-Service and those enrolled in a health plan, there is no copay for preventive services. MDCH considers preventive services to include those cited in the Preventive Services subsection.
MSA 14-34	8/28/2014	Billing & Reimbursement for Institutional Providers	6.2.J. Inpatient Hospital Claim Requirements for Newborns (new subsection; following subsection re-numbered)	New subsection text reads: Providers are required to adhere to NUBC guidelines for reporting newborn priority (type of) admission or visit and newborn birth weight. Birth weight should be reported as a whole number. For example, if the birth weight is 2764.5 grams, then the NUBC value code should be reported as "2765".
		Hospital	3.19.A. Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation	Addition of 3rd paragraph: Providers are expected to report the appropriate NUBC condition codes for gestational age on the mother's hospital claim when the delivery is related to cesarean sections or inductions.
MSA 14-33	8/28/2014	Dental	9.1 Coverage and Service Area Information	In the 1st paragraph, 1st sentence, text was revised to read "… in 80 counties." In the 2nd paragraph, the following counties were added: Kalamazoo (39) and Macomb (50)

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			9.2 Enrollment Information	Text in the 2nd and 3rd paragraphs was relocated to a new subsection: 9.2.B. Verification of Enrollment.
			9.2.A. Healthy Michigan Plan Beneficiaries - Ages 19 and 20 (new subsection)	New subsection text reads: Healthy Michigan Plan beneficiaries ages 19 and 20 who reside in a ***Healthy Kids Dental*** county are covered by the ***Healthy Kids Dental*** program until such time the beneficiary is enrolled in a health plan. The health plan becomes responsible for the beneficiary's dental services on the enrollment effective date. Health plan enrollees must obtain dental services through the health plan's dental provider network.
			9.2.B. Verification of Enrollment (new subsection)	New subsection text reads: Verification of beneficiary enrollment in Medicaid or Healthy Kids Expansion may be obtained through CHAMPS Eligibility Inquiry. The CHAMPS Eligibility Inquiry and 270/271 response will report "FFS Dental" for beneficiaries who have Fee for Service Dental. Verification of beneficiary enrollment in the ***Healthy Kids Dental*** program may be obtained through the dental benefits administrator. (Refer to the Directory Appendix for contact information.)
		Directory Appendix	Eligibility Verification	Addition of: Contact/Topic: ***Healthy Kids Dental*** [Delta Dental Automated Service Inquiry (DASI)] Phone #/Fax #: 1-800-482-8915 Mailing/Email/Web Address: http://www.deltadentalmi.com/Dentists.aspx Information Available/Purpose: Verification of enrollment in the Healthy Kids Dental program.

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