MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 15-35

Distribution: All Providers

Issued: September 1, 2015

Subject: Updates to the Medicaid Provider Manual; ICD-10 Project Update; Discontinued Coverage of Laboratory Procedure Code

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 Health and Human Services (MDHHS) has completed the October 2015 update of the online version of the Medicaid Provider Manual. The manual will be available October 1, 2015 at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Policy Manual.

If changes were made in a chapter, a note will appear in the affected section/subsection title of that chapter's table of contents. If both technical and bulletin incorporation changes apply to the section/subsection, color coding will be limited to reflect a bulletin-related change.

Please 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.

ICD-10 Project Update

ICD-10 Clinical Modification (CM) and ICD-10 Procedure Code Set (PCS) codes will be required for Health Insurance Portability and Accountability Act (HIPAA) covered entities with dates of service on or after October 1, 2015. Claims with a date of service on or after October 1, 2015 will be rejected if they do not contain a valid ICD-10 code. For additional guidance regarding claims submission and processing, refer to Bulletin MSA-13-33; the October 1, 2015 implementation date replaces the previous date(s) provided.

MDHHS encourages providers to closely monitor all post-implementation transactions and processes in order to improve beneficiary health, seek ways to make program improvements, and be cost effective with Medicaid funds.

Any questions regarding ICD-10 implementation should be directed to MDCH-ICD-10@michigan.gov. Providers should continue to frequently check the MDHHS website at www.michigan.gov/5010icd10 for ICD-10 updates and any post implementation webinar sessions at www.michigan.gov/medicaidproviders >> Hot Topics >> Medicaid Provider Training Sessions.

Discontinued Coverage of Laboratory Procedure Code

MDHHS will be discontinuing coverage of procedure code 84830 – Ovulation Tests effective September 30, 2015.

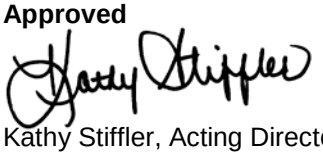
Manual Maintenance

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 MDHHS 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, Michigan Department of Health and Human Services, 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



Kathy Stiffler, Acting Director
Medical Services Administration

Michigan Department of Health and Human Services

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	6.3 Payment Suspension	The last sentence was revised to read: All payment suspensions will include referral to the MDHHS Office of Inspector General.	Due to office name change as a result of the merger.
General Information for Providers	16.1 MDHHS Office of Health Services Inspector General	The subsection title was revised to read: MDHHS Office of Inspector General Text was revised to read: The MDHHS Office of Inspector General, as a federal mandate (42 CFR 455.14), is responsible for investigating all suspected Medicaid provider (FFS or managed care) fraud and/or abuse. To report suspected fraudulent activities to MDHHS, contact the Office of Inspector General. (Refer to the Directory Appendix for contact information.) Suspected fraud and/or abuse is referred by the Office of Inspector General to the Michigan Department of the Attorney General, Medicaid Fraud Control Unit.	Due to office name change as a result of the merger.
General Information for Providers	16.3 Federal Law	In the 3rd paragraph, the 1st sentence was revised to read: To report fraudulent activities to the federal investigators, contact the Office of Inspector General of the U.S. Department of Health & Human Services (HHS).	In order to distinguish between the State OIG and the US OIG.
Beneficiary Eligibility	Section 2 – mihealth Card	The 11th paragraph was revised to read: Suspected cases of beneficiary program abuse should be sent to the MDHHS Office of Inspector General.	Due to office name change as a result of the merger.
Beneficiary Eligibility	2.1 Benefit Plans	Changes to the table include: • For Benefit Plan ID DHIP: "Benefit Plan Name" was revised to read "Foster Care and CPS Incentive Payment" • For Benefit Plan ID INCAR-ESO: "Type" was revised to read "Fee for Service" and "Covered Services" was revised to read "48" • For Benefit Plan ID INCAR-MA-E: "Type" was revised to read "Fee for Service" and "Covered Services" was revised to read "48"	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	8.2.C. Offset to Patient-Pay Amount for Noncovered Services	In the 1st paragraph, text was reformatted and added. The 1st paragraph now reads: **Notes:** • **Pre-Eligibility Medical Expenses:** This section does not pertain to Pre-Eligibility Medical Expenses (PEME). PEME must not be reported on the claim. (Refer to the Directory Appendix for PEME contact information.) • **Private insurance premiums:** Premiums for private insurance cannot be reported on a claim to Medicaid as an offset to the patient-pay amount. The cost of insurance premiums must be handled by the beneficiary's local MDHHS office worker. The MDHHS worker will determine if the cost of the insurance is an allowable expense/offset. Any cost of a premium is not permissible on a claim submitted to Medicaid.	Clarification.
Billing & Reimbursement for Professionals	6.1 General Information	Under "Diagnosis Coding" text was revised to read: Use ICD coding conventions to report the diagnosis code(s) at the highest level of specificity and with the correct number of digits. An external cause code cannot be reported as a primary diagnosis. If an external cause code is reported as primary, or if a code requires additional digits, the claim will reject.	Update.
Ambulance	1.5 Diagnosis Coding	The subsection title was revised to read "Diagnosis Codes". The 1st paragraph was revised to read: Providers must enter the appropriate ICD diagnosis code on all ambulance claims. Providers must report the most specific diagnosis code available that identifies the reason for the service. When billing for emergency transports, refer to the Covered Services Section, Emergency subsection of this chapter. For allowable diagnosis codes, refer to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Ambulance	2.6 Emergency	The 3rd paragraph was revised to read: To assure appropriate coverage and reimbursement for emergency ambulance services, MDHHS maintains a list of diagnosis codes for emergency ambulance transport. For allowable diagnosis codes, refer to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)	Update.
Children's Special Health Care Services	Throughout chapter	The term "client" was revised to read "beneficiary".	Make chapter language consistent with language throughout entire Medicaid Provider Manual.
Children's Special Health Care Services	Section 3 - Medical Eligibility	In the table in the 2nd paragraph: • Under "Diagnosis", the 1st sentence was revised to read: The individual must have a CSHCS qualifying diagnosis where his activity is or may become so restricted by disease or other medical condition as to reduce his normal capacity for education and self-support. • Under "Severity of Condition", text was revised to read: The severity criteria is met when it is determined by the MDHHS medical consultant that specialty medical care is needed to prevent, delay, or significantly reduce the risk of activity becoming so restricted by disease or other medical condition as to reduce the individual's normal capacity for education and self-support.	Language from revisions to Public Health Code.
Children's Special Health Care Services	Section 3 - Medical Eligibility	In the table in the 2nd paragraph, under "Need for Treatment by a Physician Subspecialist", text was revised to read: The condition must require treatment by a medical and/or surgical subspecialist at least annually, as opposed to being managed exclusively by a primary care physician.	Clarifying beneficiaries must need treatment (not a service).
Children's Special Health Care Services	12.1 Medicaid	Text was revised to read: Beneficiaries may have both Medicaid and CSHCS coverage. The beneficiary must comply with Medicaid requirements.	Remove misleading statement as it makes it looks like CSHCS covers first; which it doesn't.

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CHAPTER	SECTION	CHANGE	COMMENT
Children's Special Health Care Services	12.2 MIChild	Text was revised to read: Beneficiaries may have both MIChild and CSHCS coverage. The beneficiary must comply with MIChild requirements. CSHCS is not considered health insurance for purposes of MIChild eligibility.	Remove misleading statement as it makes it look like CSHCS covers first, which it doesn't.
Children's Special Health Care Services	12.4 Maternity Outpatient Medical Services	Text was revised to read: Beneficiaries may have both MOMS and CSHCS coverage. The beneficiary must comply with MOMS requirements.	Remove misleading statement as it makes it look like CSHCS covers first, which it does not.
Children's Special Health Care Services	12.6 Medicare (new subsection)	New subsection text reads: Beneficiaries may have both Medicare and CSHCS. The beneficiary must comply with Medicare requirements.	Add language to clarify coverage requirements.
Children's Special Health Care Services	12.7 Healthy Michigan Plan (new subsection)	New subsection text reads: Beneficiaries may have both the Healthy Michigan Plan and CSHCS. The beneficiary must comply with the Healthy Michigan Plan requirements.	Add language to clarify coverage.
Chiropractor	3.1 Diagnostic Codes	The subsection title was revised to read "Diagnosis Codes".	Clarification.
Dental	4.1.B. Surgical Setting	The 1st and 2nd sentences were revised to read: For services performed in a surgical setting, the dentist should use the usual and customary (U & C) fee for the service as performed in an office setting. In addition, the CDT procedure code for hospital or ambulatory surgical center call may also be billed if services are provided in a hospital or surgical center.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Early and Periodic Screening, Diagnosis and Treatment	Section 3 – History and Well Child Visits	The 2nd paragraph was revised to read: Well child visits are the health check-ups, newborn, well baby, and well child exams represented by appropriate Current Procedural Terminology (CPT) preventive medicine services procedure codes and are used in conjunction with the following International Classification of Diseases (ICD) diagnosis codes: ICD-9: V20.0 - V20.2, V20.31, V20.32, and/or V70.0, and/or V70.3 - V70.9. ICD-10: Z76.2, Z00.110, Z00.111, Z00.121, Z00.129, and/or Z00.00-01, and/or Z02.0-Z02.6, Z02.81-Z02.83, Z02.89, Z00.5, Z00.6, Z00.70, Z00.71, Z00.8.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Early and Periodic Screening, Diagnosis and Treatment	8.5 Blood Lead Screening	In the table in the 3rd paragraph, text under "Other" was revised to read: • Cosmetics (e.g., Kohl, sindoor) • Food/spices and/or food additives (e.g., Greta, Azarcon, pay-loo-ah, ghasard, Hai ge fen, Bali Goli, Kandu, Xyoo- Fa, Mai ge fen, poying tan, lozeena, turmeric, hot sauce, some Mexican candy) The 7th paragraph was revised to read : Michigan has an established statewide blood lead registry. This requires that certain information accompany each blood lead specimen (or request, if the specimen is drawn elsewhere). ▪ If blood lead samples are sent to the MDHHS Bureau of Laboratories – Trace Metals Section: ➢ Providers must obtain a Submitter Clinic Code prior to sending blood lead samples. Providers may obtain a Submitter Clinic Code by contacting the MDHHS Bureau of Laboratories – Data and Specimen Handling (DASH) Unit. (Refer to the Directory Appendix for contact information.) ➢ The "Blood Lead Test Requisition" form (DHHS-0696) must be used. (The form is available on the MDHHS website. Refer to the Directory Appendix for website information.)	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
		▪ If blood lead samples are sent to a private laboratory or if the private laboratory draws and tests the sample, the provider must include the following: ➢ information with respect to the individual tested (name, sex, ethnicity, race, birthdate, address (and, to the extent available, whether the residence or property is owned or rented), telephone number, Medicaid number, parent/guardian (if individual is a minor), employer (if individual is an adult), secondary contact (name and phone number) for individual tested or parent/guardian; ➢ date of the sample collection; ➢ the type of sample (capillary or venous); and ➢ provider's name, name of practice (if applicable), telephone number, fax number, e-mail address, and mailing address. When testing is completed, the laboratory completes the required information and submits it to the blood lead registry. The 9th paragraph was revised to read: The MDHHS Bureau of Laboratories – Trace Metals Section will report all results to the child's ordering provider. All clinical laboratories in Michigan that analyze blood samples for lead shall report all blood lead results, ...	

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CHAPTER	SECTION	CHANGE	COMMENT
Early and Periodic Screening, Diagnosis and Treatment	Section 11 – Children in Foster Care	Text presented in the 1st paragraph was revised to read: Medical interventions, screenings, and various preventive health care services are to be up-to-date for all children in foster care. For purposes of this section, any reference to "child" or "children" in foster care includes any individual in foster care who is younger than 21 years of age. The care of children should be comprehensive, well-coordinated, and fully documented throughout their stay in foster care. All children in foster care younger than 21 years of age must receive a full medical examination and screening for potential mental health issues by a PCP within the first 30 days after entering foster care. All children in foster care are eligible for Medicaid from the first day of the month of entry into foster care. The PCP must verify the child in foster care's eligibility and enrollment status. In case of difficulty confirming Medicaid status, or of verifying Medicaid Health Plan enrollment, the PCP should contact the foster care worker or the local MDHHS office designee. The PCP must complete the health maintenance visit regardless of whether or not the child in foster care recently received a health maintenance visit prior to entry into the foster care system. The PCP's office staff should obtain the completed MDHHS "Consent to Routine, Non-surgical Medical Care and Emergency Medical or Surgical Treatment" form (DHS-3762) from the foster care parent, or consent from the child in foster care if the child is at least 18 years of age, before the child is seen by the PCP. This form provides the PCP with informed consent to routine, non-surgical medical care and emergency medical or surgical treatment and provides the child's foster care worker's or local MDHHS office designee's contact information. This form does not grant informed consent for the physician to provide psychotropic medication treatment. The MDHHS "Psychotropic Medication Informed Consent" form (DHS-1643) must be completed to receive informed consent to provide psychotropic medication treatment. (Refer to the MDHHS website for copies of forms and form information. Refer to the Directory Appendix for website information.)	Adding additional clarifying language and direction for providers. Adding an additional resource.

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CHAPTER	SECTION	CHANGE	COMMENT
		Text previously formatted as the 2nd paragraph (now the 3rd paragraph) was revised to read: A child may be assigned to a new PCP upon entry into the foster care system, and it will be necessary for the child's previous PCP to share the child's health information with the new PCP. In an order placing a child in foster care, the court shall include an order that each of the child's medical providers release the child's medical records. The court order requires the parent(s) to provide names and contact information for all previous medical and mental health providers, and to sign a consent to release health information on the day of the court proceedings. Text previously formatted as the 3rd paragraph was deleted. The 4th paragraph was revised to read: The supervising agency shall develop a medical passport for each child who comes under its care. The medical passport shall contain all medical information required by policy or law to be provided to the PCP and to the foster care parent. The medical passport includes a basic medical history, a record of all immunizations from the Michigan Care Improvement Registry (MCIR), a complete and regularly updated statement of medical appointments, prescribed medications, and any other information available to the foster care worker concerning the child's medical, physical, and mental health status. The medical passport should be shared with the child's foster care parents and all medical providers even if the document is not complete or up to date. Updates to the medical passport should be shared with the foster care parents and medical providers when new information becomes available. If health information, including the medical passport, is not made available to the medical provider at or before the time of the medical examination, the medical provider should contact the foster care worker and/or the local MDHHS office designee (noted on the DHS-3762 form) to assist with obtaining the missing health information.	Removal of language pertaining more to the foster care worker. Adding additional clarifying language and direction for providers.

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		The 7th paragraph was revised to read: A developmental/behavioral assessment must be completed according to the recommendations of the AAP. A developmental/behavioral assessment includes developmental screening, autism screening, developmental surveillance, psychosocial/behavioral assessment, alcohol and drug use assessment, and depression screening. Screening for these potential developmental/behavioral issues is accomplished by using an objective validated and standardized screening tool and should be completed with the assistance of a person who knows the child best. This may be the child's biological parent, foster care parent, caregiver, or other adult who knows the child. The foster care worker is available to assist the provider in identifying the person who knows the child best. The psychosocial/behavioral assessment is required at each scheduled well child visit and may be accomplished by surveillance or by using a validated and standardized screening tool such as the ASQ-SE or PSC with appropriate action to follow if the assessment is positive. PCPs should use a validated and standardized screening tool for all children in foster care and for children with mental health conditions. The use of validated and standardized screening tools improves the detection rate of social-emotional problems of children in foster care compared to the reliance on subjective clinical judgment (i.e., surveillance). The foster care worker is trained in the use of the ASQ-SE and PSC. If the physician chooses to use either of these tools, the foster care worker is available to assist in completing the screening tool and ensure that it is made available to the medical provider for scoring and for incorporation into the treatment plan. The individual accompanying the child to the medical examination should present the completed screening tool to the PCP at the initial appointment or for any other periodic examinations. The PCP is responsible for scoring and interpreting the results of the screening tool and proposing recommendations regarding follow-up. (Refer to the Directory Appendix for foster care resources.)	A more appropriate term (developmental/behavioral) is replacing a less appropriate term (mental health). Language indicating "the child within 30 days of entering foster care" is redundant. Language indicating "preferably for at least 30 days" is not needed since such a person may not be available and "a person who knows the child best" is sufficient. Adding language indicating who can help identify this individual. Removal of language pertaining more to the foster care worker. Language was added to make it clear that the foster care worker is trained in the use of these tools and is available to assist the provider in completing the tools if the provider chooses to use either tool. In addition, the language was moved near the end of the paragraph where it is more appropriate.

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CHAPTER	SECTION	CHANGE	COMMENT
Early and Periodic Screening, Diagnosis and Treatment	12.4.B. Blood Lead Nursing Assessment Visits	In the 2nd paragraph, the last sentence was deleted.	Removing language to maintain consistency with other chapters.
Family Planning Clinics	1.3 Diagnosis Codes	Subsection text was revised to read: The appropriate ICD diagnosis code(s) must be indicated on the claim form when billing for family planning services. For dates of service (DOS) before 10/1/15, family planning services are limited to the V25 (ICD-9) diagnosis code range. For DOS on and after 10/1/15, family planning services are limited to the Z30 (ICD-10) code range. Providers must enter the appropriate code on the claim form.	Update.
Family Planning Waiver	1.3 Reimbursement	The 1st paragraph was revised to read: MDHHS reimburses for services provided to beneficiaries who meet the eligibility requirements of the Plan First! Family Planning Waiver. Only family planning services are covered under this waiver. Providers must use the appropriate V25 (ICD-9) or Z30 (ICD-10) diagnosis code as the primary diagnosis on the claim in order to receive reimbursement.	Update.
Family Planning Waiver	1.4 Diagnosis Codes	Subsection text was revised to read: The appropriate ICD diagnosis code(s) must be indicated on the claim form when billing for family planning services. Family planning services are limited to the V25 (ICD-9) or Z30 (ICD-10) diagnosis code series range. Providers must enter the appropriate V25 (ICD-9) or Z30 (ICD-10) diagnosis code as the primary diagnosis on the claim form for services rendered.	Update.
Hospital Reimbursement Appendix	1.3 Status Indicators	The following information was added to the table in the 2nd paragraph: **Status Indicator** / **Description** / **Comments** A7 / State Plan Reimbursement / A8 / Healthy Michigan Plan Only /	Additional clarification – current applicable status indicators.

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CHAPTER	SECTION	CHANGE	COMMENT
Maternal Infant Health Program	1.4 Medicaid Health Plans (MHP)	The last sentence was revised to read: (Refer to the Forms Appendix for an example of a Care Coordination Agreement.)	Clarification.
Medical Supplier	2.13.A. Enteral Nutrition (Administered Orally)	Under "PA Requirements", the following text was added: The following HCPCS codes require authorization via a telephone authorization process: B4034, B4035, B4036, B4081, B4082, B4083 B4087, B4088, B4102, B4149, B4150, B4152 B4153, B4154, B4155, B4157, B4158, B4159 B4160, B4161, B4162, B9000, B9002, B9998 Refer to the Directory Appendix for Telephone Prior Authorization Contractor information.	Update.
Medical Supplier	2.13.B. Enteral Nutrition (Administered by Tube)	Under "PA Requirements", the following text was added: The following HCPCS codes require authorization via a telephone authorization process: B4034, B4035, B4036, B4081, B4082, B4083 B4087, B4088, B4102, B4149, B4150, B4152 B4153, B4154, B4155, B4157, B4158, B4159 B4160, B4161, B4162, B9000, B9002, B9998 Refer to the Directory Appendix for Telephone Prior Authorization Contractor information.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Medical Supplier	2.16 Home Intravenous Infusion Therapy	Under "PA Requirements", the following text was added: When PA is required the following HCPCS codes are authorized via a telephone authorization process: S5498, S5501, S5502, S5520 S5521, S9326, S9327, S9330 S9331, S9338, S9345, S9346 S9348, S9351, S9355, S9374 S9375, S9376, S9377, S9379 S9490, S9497, S9500, S9501 S9502, S9503, S9504, S9537 Refer to the Directory Appendix for Telephone Prior Authorization Contractor information.	Update.
Medical Supplier	2.17 Home Uterine Activity Monitor	Under "PA Requirements", the following text was added: HCPCS code S9001 requires authorization via a telephone prior authorization process. (Refer to the Directory Appendix for Telephone Prior Authorization Contractor information.)	Update.
Medical Supplier	2.23 Negative Pressure Wound Therapy (Pump and Accessories)	Under "PA Requirements", the following text was added: HCPCS codes A6550, A7000 and E2402 require authorization via a telephone prior authorization process. (Refer to the Directory Appendix for Telephone Prior Authorization Contractor information.)	Update.

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Medical Supplier	2.29 Osteogenesis Stimulators	Under "Standards of Coverage", 1st paragraph, the 6th bullet point was revised to read: • A nonunion of a long bone fracture as described by the appropriate ICD code. Under "Standards of Coverage", 2nd paragraph, the 1st through 4th bullet points were revised to read: • There is a failed spinal fusion where a minimum of nine months has elapsed since the last surgery. • Following multi-level (three or more vertebrae) spinal fusion surgery without instrumentation. • Clinical indication in cervical spine fusions with instrumentation (reviewed on case by case basis). • Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same level(s). How long ago was the failure?	Update.
Medical Supplier	2.32 Parenteral Nutrition	Under "PA Requirements", the following text was added: When PA is required the following HCPCS codes are authorized via a telephone authorization process: B4185, B4189, B4193, B4197, B4199 B4220, B4224, B9004, B9006, B9999 Refer to the Directory Appendix for Telephone Prior Authorization Contractor information.	Update.
Mental Health/ Substance Abuse	3.29.E Evaluation and Outcomes Measurement	The 2nd bullet point was revised to read: • Ensure completion of the Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS) at intake, quarterly, and at graduation.	Correction.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	4.4 Eligibility Criteria	In the 2nd paragraph, under "Diagnosis", text was revised to read: The beneficiary must have a serious mental illness, as reflected in a primary, validated, current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).	Update.
Mental Health/ Substance Abuse	7.2.A. Birth Through Age Three	In the 3rd paragraph, under "Diagnosis", text was revised to read: A child has an intellectual, behavioral, or emotional disorder sufficient to meet diagnostic criteria (specified within the current version of the DSM or ICD consistent with the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood; Revised Edition) not solely the result of an intellectual disability or other developmental disability, drug abuse/alcoholism or those with an ICD-9 V-code or ICD-10 Z-code diagnosis, and the beneficiary meets the criteria listed below for degree of disability/functional impairment and duration/service history.	Update.
Mental Health/ Substance Abuse	7.2.B. Age Four Through Six	In the 1st paragraph, under "Diagnosis", text was revised to read: A child has an intellectual, behavioral or emotional disorder sufficient to meet diagnostic criteria specified within the current version of the DSM or ICD not solely the result of an intellectual disability or other developmental disability, drug abuse/alcoholism or those with an ICD-9 V-code or ICD-10 Z-code diagnosis, and the beneficiary meets the criteria listed below for degree of disability/functional impairment and duration/service history.	Update.
Mental Health/ Substance Abuse	7.2.C. Age Seven Through Seventeen	In the 1st paragraph, under "Diagnosis", text was revised to read: The child/adolescent currently has, or had at any time in the past, a diagnosable behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current version of the DSM or ICD, excluding those with a diagnosis other than, or in addition to, alcohol or drug disorders, a developmental disorder, or social conditions (ICD-9 V-codes and ICD-10 Z-codes).	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	8.5.B. Inpatient Admission Criteria: Adults	In the 3rd paragraph, under "Diagnosis", text was revised to read: The beneficiary must be suffering from a mental illness reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).	Update.
Mental Health/ Substance Abuse	8.5.C. Inpatient Admission Criteria: Children Through Age 21	In the 3rd paragraph, under "Diagnosis", text was revised to read: The beneficiary must be suffering from a mental illness reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).	Update.
Mental Health/ Substance Abuse	8.5.D. Inpatient Psychiatric Care – Continuing Stay Criteria: Adults, Adolescents and Children	In the 4th paragraph, under "Diagnosis", text was revised to read: The beneficiary has a validated current version of DSM or ICD mental disorder (excluding ICD-9 V-codes and ICD-10 Z-codes) that remains the principal diagnosis for purposes of care during the period under review.	Update.
Mental Health/ Substance Abuse	10.1 Partial Hospitalization Admission Criteria: Adult	In the 3rd paragraph, under "Diagnosis", text was revised to read: The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM or ICD Diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).	Update.
Mental Health/ Substance Abuse	10.2 Partial Hospitalization Admission Criteria: Children and Adolescents	In the 3rd paragraph, under "Diagnosis", text was revised to read: The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).	Update.
Mental Health/ Substance Abuse	10.3 Partial Hospitalization Continuing Stay Criteria for Adults, Adolescents and Children	In the 4th paragraph, under "Diagnosis", text was revised to read: The beneficiary has a validated current version of DSM or ICD mental disorder (excluding ICD-9 V-codes and ICD-10 Z-codes), which remains the principal diagnosis for purposes of care during the period under review.	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	10.37.C. Non-Emergency Ambulance	The following text was added after the 1st sentence: The written order must contain, at a minimum, the following information: • Beneficiary's name and Medicaid identification (ID) number; • Attending physician's NPI number and attending physician or provider signature; • Type of transport necessary; • Explanation of the medical necessity for ambulance transport (i.e., why other means of transport could not be used); • Origin and destination; • Diagnosis; • Frequency of needed transports (required for ongoing, planned treatment); and • Type of ongoing treatment (required for ongoing, planned treatment). 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 60 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.	For non-emergency ambulance, the physician's order requires additional elements (e.g., diagnosis). This information is currently published policy for ambulance providers.
School Based Services Random Moment Time Study	9.2.B. MDHHS Office of Health Services Inspector General – Post Payment Review and Compliance	The subsection title was revised to read: MDHHS Office of Inspector General – Post Payment Review and Compliance The 1st sentence was revised to read: MDHHS Office of Inspector General staff responsibilities are:	Due to office name change as a result of the merger.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Vision	3.1 Diagnostic Services	In the 2nd paragraph, under "Eye Examinations", the 1st bullet point was revised to read: • A routine eye examination once every two years is a Medicaid benefit and does not require PA. Examinations include, but are not limited to, case history, determination of visual acuity (each eye), ophthalmoscopy, biomicroscopy, ocular motility, tonometry, refraction, diagnosis, treatment program and disposition. (Use appropriate CPT/HCPCS procedure codes for routine eye exam and applicable ICD diagnosis codes. In the 2nd paragraph, under "Glaucoma Screenings", the 2nd paragraph was revised to read: This screening entails a dilated eye examination, tonometry, and direct ophthalmoscopy or slit lamp examination. If this screening is provided as part of another billable service, separate reimbursement for this screening is not allowed. Use the appropriate CPT/HCPCS procedure code for glaucoma screening and the applicable ICD diagnosis code.	Update.
Directory Appendix	Prior Authorization (Authorization of Services)	Under Program Review Division (FFS Medicaid & CSHCS), text under "Information Available/Purpose" was revised to read: Prior authorization for all services except hospital, specified durable medical equipment, and pharmacy.	Update.
Directory Appendix	Prior Authorization (Authorization of Services)	Under: "Contact/Topic" for "Prior Authorization - Specified DME and Medical Supplies (MDHHS Medicaid Prior Authorization Contractor)", text was revised to read: (MDHHS Medicaid Telephone Prior Authorization Contractor) Under "Information Available/Purpose", text was revised to read:: Telephone prior authorization of specified DME and medical supplies (applies to applicable procedure codes requiring telephone prior authorization noted on the MDHHS Medical Suppliers/Orthotists/Prosthetists/DME Dealers page on the MDHHS website)	Update.

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TECHNICAL CHANGES*

<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td>Directory Appendix</td><td>Provider Resources</td><td>Under “MDHHS Bureau of Laboratories – Trace Metals Section”, text was revised to read:
Contact/Topic: MDHHS Bureau of Laboratories –Data and Specimen Handling (DASH) Unit
Phone # Fax #: 517-335-8059 Fax 517-335-9871
Information Available/Purpose: Obtain clinic code; Download Blood Lead Test Request form (DHHS-0696)</td><td>Update.</td></tr>
<tr><td>Directory Appendix</td><td>Provider Resources</td><td>Under “MDHHS Childhood Lead Poisoning Prevention Program”, text was revised to read:
Web Address: www.michigan.gov/lead
Information Available/Purpose: Education and outreach related to blood lead poisoning</td><td>Update.</td></tr>
<tr><td>Directory Appendix</td><td>Provider Resources</td><td>Under “MDHHS Healthy Homes Section”, text was revised to read:
Web Address: www.michigan.gov/leadsafe</td><td>Update.</td></tr>
<tr><td>Directory Appendix</td><td>Provider Resources</td><td>The following information was added:
<table>
<tr><th>Contact/Topic</th><th>Phone # Fax #</th><th>Mailing/Email/Web Address</th><th>Information Available/Purpose</th></tr>
<tr><td>MDHHS Bureau of Laboratories – Warehouse</td><td>517-335-9040 Fax 517-335-9039</td><td>Email: mdhhslab@michigan.gov</td><td>Order testing supplies</td></tr>
<tr><td>MDHHS Bureau of Laboratories, Trace Metals Section</td><td>517-335-8244</td><td>Website: www.michigan.gov/mdchlab</td><td>Lead testing (technical questions)</td></tr>
</table></td><td>Update.</td></tr>
</table>

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<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td>Directory Appendix</td><td>Maternal Infant Health Program Resources</td><td>The following information was added:

<table><tr><th>Contact/Topic</th><th>Phone # Fax #</th><th>Mailing/Email/Web Address</th><th>Information Available/Purpose</th></tr><tr><td>Maternal Infant Health Program</td><td></td><td>http://www.michigan.gov/mihp</td><td>Information regarding MIHP enrollment and operations, including the MIHP Operations Guide, forms, and contact information.</td></tr><tr><td>Text4baby</td><td></td><td>https://www.text4baby</td><td>Service providing information for pregnant and postpartum women</td></tr><tr><td>Great Start Collaborative</td><td></td><td>http://greatstartforkids.org/content/great-start-network</td><td>Helps parents find the best early learning settings for their children and helps providers and educators improve the care they give to their children.</td></tr><tr><td>Early On Michigan</td><td>1-800-EarlyOn

Fax 517-668-2505</td><td>https://1800earlyon.org/index.php</td><td>Early intervention services for infants and toddlers, birth to three years of age with developmental delay (s) or disabilities.</td></tr></table></td><td>Update.</td></tr>
<tr><td>Directory Appendix</td><td>Reporting Fraud, Abuse or Misuse of Services</td><td>Under “Contact/Topic”, “MDHHS Office of Health Services Inspector General” was revised to read “MDHHS Office of Inspector General”.

The Mailing Address was revised to read:

Michigan Department of Health and Human Services
Office of Inspector General</td><td>Due to office name change as a result of the merger.</td></tr>
</table>

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Reporting Fraud, Abuse or Misuse of Services	Under "Contact/Topic", "Office of Inspector General" was revised to read: Office of Inspector General of the U.S. Department of Health & Human Services (HHS) The Mailing Address was revised to read: Office of Inspector General of the U.S. Department of Health & Human Services (HHS)	In order to distinguish between the State OIG and the US OIG.

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<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td rowspan="2">MSA 15-28</td><td rowspan="2">7/1/2015</td><td>Billing & Reimbursement for Professionals</td><td>7.6.B. New/Used DME</td><td>Modifier information was revised as follows:
<table>
<tr><th>Modifier</th><th>Description</th><th>Special Instructions</th></tr>
<tr><td>NU</td><td>New DME Equipment</td><td>Use for the purchase of a new DME item. (Refer to the Medical Supplier database and the Medicaid Code and Rate Reference Tool for codes that require the NU modifier.)</td></tr>
<tr><td>UE</td><td>Used durable medical equipment</td><td>Use for the purchase of used DME equipment. (Refer to the Medical Supplier database and the Medicaid Code and Rate Reference Tool for codes that require the UE modifier.)</td></tr>
</table></td></tr>
<tr><td>Medical Supplier</td><td>1.8.D. Used Equipment
(new subsection)</td><td>New subsection text reads:
<u>Definition</u>
Used durable medical equipment is defined as non-customized equipment previously purchased or rented by one or more users, or equipment utilized as floor models, demonstration equipment or loaner equipment prior to current purchase or rental.
<u>Standards of Coverage</u>
Used equipment may be covered when all of the following are met:
• The provider determines the item to be the least costly alternative that meets the beneficiary's medical/functional needs; and
• The equipment and components are non-customized items; and
• The equipment is not intended or labeled as a single user item; and
• The equipment is in good working condition and comparable to new equipment quality standards; and
• The equipment has been sanitized, repaired and reconditioned between each user.
Prior to the provision of used equipment, the beneficiary/parent/legal guardian must</td></tr>
</table>

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				be given a choice to accept or refuse used equipment. If the beneficiary chooses to not accept the used equipment, the provider must provide new equipment following the standards of coverage and payment rules indicated in policy. MDHHS suggests that used equipment be identified by affixing a tag to the item with the equipment age and make/model/serial number or other identifying information. Providers offering used equipment are responsible to clean, repair and recondition used items between users to assure the equipment is safe and in good working condition. The provider must remove used items from service when such items no longer meet quality standards. <u>Documentation</u> In addition to documentation requirements listed in the this chapter, documentation for used equipment must include: • Equipment service log ➢ Confirmation that the equipment has been fully serviced and is in good working condition; ➢ Repair(s) and sanitization dates, with signature(s) of person(s) performing these functions; ➢ Age of item (if known); ➢ Serial number/make/model (or other identifying information); and ➢ Warranty information. The above information must be incorporated into the beneficiary's file upon rental/purchase of the item. • Beneficiary file ➢ Signed and dated agreement from the beneficiary/parent/legal guardian stating he/she understands the equipment is used; ➢ Indication that a manufacturer's owner's manual was provided to the beneficiary; and

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				➢ Provider attestation that the used equipment is durable enough to meet Medicaid minimum frequency limits for replacement equipment. Documentation must be available upon MDHHS request. Refer to the specific policy standards of coverage and documentation requirements listed in this chapter. <u>PA Requirements</u> Prior authorization is not required for used equipment if PA is not required for a new item with the same HCPCS code assignment. PA is required for coverage beyond the standards of coverage, repair/replacement rules, and frequency limits indicated for the specified equipment. <u>Payment Rules</u> Used equipment may be purchased or rented (up to specified rental periods listed in policy). Repairs/reconditioning/sanitizing and labor costs are included in the initial purchase and rental period per each beneficiary. All warranties must be exhausted prior to requesting prior authorization for repair or replacement of the equipment per beneficiary. MDHHS has identified specific items that must have either the NU or UE modifier appended to the HCPCS code when requesting PA or submitting a claim. Failure to append the correct modifier(s) may result in denied claims or inaccurate payment. • NU - New Equipment • UE - Used Equipment Refer to the Medical Supplier database and/or the Medicaid Code and Rate Reference tool for HCPCS codes requiring the NU or UE modifier.

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<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td rowspan="2">MSA 15-25</td><td rowspan="2">7/1/2015</td><td>Billing & Reimbursement for Professionals</td><td>7.6.I. Miscellaneous Supplies</td><td>Addition of:
<table>
<tr><th>Modifier</th><th>Description</th><th>Special Instructions</th></tr>
<tr><td>KX</td><td>Specific required documentation on file.</td><td>Append to each HCPCS code A4253/A4259 when submitting claims for over quantity for adults (age 21 and older) with medical need to test their blood glucose more frequently than established quantities. Refer to the Medical Supplier Chapter and the Medicaid Code and Rate Reference tool on the MDHHS website for all coverage requirements.</td></tr>
</table></td></tr>
<tr><td>Medical Supplier</td><td>2.3 Blood Glucose Monitoring Equipment and Supplies</td><td>The following text was added to “Documentation”:

For beneficiaries 21 years of age and older with medical need to test blood glucose more frequently than established quantity limits, the physician must indicate the medical need and duration (“PRN” or “as needed” is not sufficient documentation to support medical need) for the additional quantities.

Under “PA Requirements”, the following text was added after the bullet list in the 1st paragraph:

In addition to the above, PA will not be required if physician documentation substantiates the medical need for an adult (insulin or non-insulin treated) to test more frequently than standardized MDHHS limits. For such circumstances, the provider must append the KX modifier to the A4253 and to the A4259 on the claim. (Refer to the Medicaid Code and Rate Reference tool for quantity limits when using modifier KX with lancets and test strips).

In the 2nd paragraph, the 2nd bullet point was revised to read:

• Medical need not within the Standards of Coverage if it exceeds quantity limits and/or a diagnosis that has not been removed from PA.</td></tr>
</table>

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MSA 15-24	7/1/2015	Ambulance	2.9 Nonemergency	In the 4th paragraph, the 2nd sentence was revised to read: For chronic conditions, a physician may order nonemergency transportation for a maximum time period of up to 60 days in a single order.
MSA 15-22	6/1/2015	School Based Services	2.4.C. Telepractice for Speech, Language and Hearing Services (new subsection)	New subsection text reads: **Definition** Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of speech, language and hearing services. Telepractice must be obtained through real-time interaction between the patient's physical location (patient site) and the provider's physical location (provider site). Services are provided to patients through hardwire or internet connection. It is the expectation that providers, facilitators and staff involved in telepractice are trained in the use of equipment and software prior to servicing patients. Speech, language and hearing services administered by telepractice are subject to the same provisions as services provided to a patient in person. **Prescription** Speech, language and hearing services require an annual referral from a physician. A stamped physician signature is not acceptable. **Provider Qualifications** Speech, language and hearing services may be reimbursed when provided by: • A fully 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 limited licensed speech language pathologist under the direction of a fully licensed SLP or audiologist. All documentation must be reviewed and signed by

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				the appropriately licensed supervising SLP or licensed audiologist. **Conditions** 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. Refer to the General Information for Providers Chapter for complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements. The patient site may be located within the school, at the patient's home, or any other established site deemed appropriate by the provider. It must be a room free from distractions so as not to interfere with the telepractice session. A facilitator must be trained in the use of the telepractice technology and physically present at the patient site during the entire telepractice session to assist the patient at the direction of the SLP or audiologist. **Billing Instructions** Telepractice services are billed using the same procedure codes as services rendered to a patient who is physically present. In addition to the procedure code, billers use the "GT" modifier to identify services provided by telepractice.
MSA 15-21	6/1/2015	Children's Special Health Care Services	2.4 Children's Multi-Disciplinary Specialty (CMDS) Clinic Requirements	The 2nd paragraph was revised to read: CSHCS-approved organizations with responsibility for CMDS clinics must enroll through the online Michigan Department of Health and Human Services (MDHHS) Community Health Automated Medicaid Processing System (CHAMPS) Provider Enrollment (PE) subsystem to be reimbursed for clinic fees for services rendered to eligible CSHCS beneficiaries. Each CMDS clinic must operate under the unique CMDS National Provider Identifier (NPI) held by the organization responsible for those CMDS clinics and must identify the providers who render the services in the CMDS clinic as affiliated providers. All affiliated providers whose services are directly reimbursable per MDHHS policy must be separately enrolled in CHAMPS and must also receive a beneficiary-specific authorization from CSHCS prior to the clinic billing for the clinic fees.

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			2.4.A. Explanation of Services	The following text was added as a 2nd paragraph: Services are provided as a comprehensive package by a team of pediatric specialty physicians and other appropriate health care professionals. CMDS clinic fees are not intended for sporadic users of the services available through CMDS clinics such as support services only. CMDS clinic fees are intended for the comprehensive, coordinated and integrated services that CMDS clinics provide to beneficiaries who return for and continue to use this full package of services.
			2.4.B. CMDS Clinic Staff Requirements	Information in the table for "Nurse" was revised to read: **Registered Nurse** A Registered Nurse (RN) currently licensed to practice under Michigan state law and having a minimum of two years of pediatric nursing experience or adult nursing experience when serving adults. Certain CMDS clinics are exempt from this requirement (e.g., the Metabolic Diseases CMDS clinics) as long as they have the appropriate additional staff as required in the CMDS Clinic Guide. Information in the table for "Dietitian" was revised to read: **Registered Dietitian** A Registered Dietitian (RD) in possession of a master's degree in human nutrition, public health, or a health-related field with an emphasis on nutrition, and two years of pediatric nutrition experience or adult nutrition experience when serving adults in providing nutrition assessment, education and counseling. Information in the table for "Social Worker" was revised to read: **Social Worker** A Licensed Master Social Worker (LMSW) or professional staff member in possession of a master's degree in social work and two years of experience in counseling and providing service to children/youth, adults and their families.

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				The following definition was added to the table: **Physician** A Medicaid-enrolled and CSHCS-authorized pediatric subspecialist, or adult subspecialist physician when serving adults, currently licensed to practice under Michigan state law with special training and demonstrated clinical experience related to the diagnoses treated by the specific CMDS clinic type. Physicians are expected to remain familiar with current developments and standards of treatment in their respective fields. Refer to the CMDS Clinic Guide, tables I and II, for subspecialty designations. The CMDS Clinic Guide is available on the MDHHS website. (Refer to the Directory Appendix for website information.)
			2.4.C. CMDS Clinic Visit Types	Subsection text was revised to read: Beneficiaries with multiple, complex diagnoses may receive CMDS coordinated services from more than one CMDS clinic. However, the limits and numbers of CMDS clinic visit types indicate what the beneficiary is eligible to receive regardless of the number of CMDS clinics the beneficiary is accessing. Any CMDS clinic serving the beneficiary under the CMDS clinic process may submit claims for the appropriate clinic fee(s) up to the limit allowed per beneficiary. For example, there are 10 Support Visits allowed per beneficiary in a year. Any organization/clinic serving the beneficiary may bill for those support visits until the beneficiary limit has been reached. That might involve one CMDS clinic receiving reimbursement for all 10 of the Support Visits or a combination of CMDS clinics receiving reimbursement for some visits until the limit has been reached. The CMDS clinics must document clinic visit levels to include the following: • Support services must be indicated in the CMDS Plan of Care (POC) developed at a CMDS clinic Comprehensive Initial or Basic Evaluation visit or Management/Follow-up visit. • The CMDS clinic must collaborate with other CMDS clinics the child/youth, adult and their family may be using regarding which CMDS clinic is the lead CMDS clinic and how the fee billing will occur in coordination between the CMDS clinics that are both serving the same beneficiary.

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MSA 15-20	6/1/2015	Nursing Facility Certification, Survey & Enforcement Appendix	2.9 Voluntary Withdrawal from Participation in the Medicaid Program or Voluntary Nursing Facility Closure	Text previously formatted as the 2nd, 3rd, and 4th paragraphs was revised to read: When a provider decides to close voluntarily, the administrator of the nursing facility must provide written notification prior to the impending closure to the: • State Survey Agency (SSA), • State Medicaid Agency (SMA) /Long Term Care (LTC) Services Section, • LTC Ombudsman, • Residents of the nursing facility, and • Legal representatives of such residents or other responsible parties. Written notice must be provided at least 60 days before the date of closure. **Note:** In cases where the Secretary of the U.S. Department of Health & Human Services (HHS) terminates the facility's participation in either the Medicare and/or Medicaid programs, notice must be provided no later than the date that the Secretary of the U.S. Department of Health & Human Services (HHS) determines appropriate for such notification. This 60-day notice requirement begins before any attempt to transfer a resident out of the facility in anticipation of a facility closure/withdrawal. The provider must ensure that no new residents are admitted on or after the date on which such written notification is submitted. The written notice of a voluntary closure must include the plan for closure. The plan must be approved by the SSA and the SMA/LTC Services Section prior to notification of residents of the closure. The plan must outline the transfer and adequate relocation of residents that assures placement in the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident. Upon approval of the plan by the SSA and the SMA/LTC Services Section, actual notice of closure must be given, which means that the notice must be given to the resident and a family member or legal representative in a form that they can understand and must be explained to them as needed. The notice must include the plan as approved by the State for the transfer and adequate relocation of the residents by the date

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				specified by the State prior to closure. It must also include assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, including home or community-based settings, taking into consideration the needs, choice, and best interests of each resident. The notice must include contact information for the LTC Ombudsman and the Area Agency on Aging.
MSA 15-16	6/1/2015	Billing & Reimbursement for Professionals	6.21 Surgery	In the 1st column, the heading "Hysterectomy and Sterilization Consent Forms" was revised to read "Hysterectomy and Sterilization Procedures". Under "Hysterectomy and Sterilization Procedures", a 2nd paragraph was added with text reading: The charge submitted to Medicaid for devices used in the sterilization process, permanent implantable contraceptive intra-tubal occlusion device and delivery system, must reflect the acquisition cost of the device and delivery system, including advertised discounts, special promotions, or other programs initiated to reduce prices for product costs (340B program).
		Family Planning Clinics	5.1 Special Billing Instructions	Text was revised to read: If a pharmaceutical, contraceptive supply, or medical device is purchased at the 340B price, the actual acquisition cost must be billed to Medicaid. (Refer to the Billing & Reimbursement for Professionals Chapter for additional information.)
MSA 15-15	6/1/2015	Pharmacy	Section 19 - Pharmacy Audit and Documentation	Section 19 – Pharmacy Audit and Documentation was reformatted to provide two subsections: • 19.1 Documentation Requirements • 19.2 Invoice and Inventory Records

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			19.1 Documentation Requirements (new subsection)	Text was relocated from Section 19 – Pharmacy Audit and Documentation.
			19.2 Invoice and Inventory Records (new subsection)	New subsection text reads: In addition to all other documentation required under state law, federal law, and MDHHS policy, pharmacy providers must maintain invoices, manufacturer and/or wholesaler sales records, distributor delivery records to the provider, inventory transfer records, provider payment records, and all other records necessary to support the size and quantity of the goods paid for by Medicaid during the audit/review period. Failure to do so will result in the recoupment of pharmacy funds related to unsupported Medicaid claims. In the event inventory for any such product cannot be substantiated through reliable documentation for the beginning of the audit/review period, MDHHS may assume that the beginning and ending inventory quantities are the same for that product. For the purposes of this policy, the "audit/review period" shall be a period defined by MDHHS.
MSA 15-08	5/1/2015	Pharmacy	14.14 Seasonal Influenza Vaccine	The subsection title was revised to read “Vaccines”. Subsection text was revised to read: All vaccines recommended by the Advisory Council for Immunization Practices (ACIP), including seasonal influenza vaccines, administered by pharmacists are covered for adults aged 19 years and older. Pharmacies may submit a claim for the vaccine and its administration for Fee-for-Service Medicaid, ABW, and MOMS beneficiaries. In addition, pharmacies may submit a claim for seasonal influenza vaccine and its administration for CSHCS beneficiaries. For beneficiaries enrolled in a Medicaid Health Plan, the pharmacy provider must confirm coverage of pharmacist-administered vaccines with the plan.

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				Pharmacists must be in compliance with State of Michigan rules and regulations, have received the appropriate training for vaccine administration, and have a letter of delegation from a physician to be eligible to administer vaccines. Standing orders are required from a Michigan-licensed physician who is responsible for the clinical practice of the vaccine operations. This documentation must be readily available onsite in the event of an audit. Pharmacists who administer vaccines must register with the Michigan Care Improvement Registry (MCIR). This database provides a complete record of immunizations for Michigan residents. Pharmacists must review the beneficiary's immunization history in MCIR prior to administering the vaccine. MCIR must be updated within 72 hours of administering the vaccine. In order to receive reimbursement for vaccine administration, pharmacies must submit claims through the MDHHS Pharmacy Benefits Manager (PBM). (Refer to the Directory Appendix for contact information.) The pharmacy must submit the National Drug Code (NDC) for the product administered and the appropriate values in the Drug Utilization Review (DUR)/Professional Pharmacy Services (PPS) segment and the Professional Service Code respectively. MDHHS allows pharmacies to bill the cost of the vaccine; therefore, the pharmacy should submit the allowed administrative fee in the incentive fee submitted field. Dispensing fees are not allowed for the administration of vaccines. The pharmacy must develop an appropriate mechanism for purposes of properly documenting the identification of the administering pharmacist. Either a pharmacy or physician can bill for the vaccine administration, but not both. Copayments for vaccine administration services do not apply.

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				Certain pharmacy providers have been selected by local health departments to administer vaccines to beneficiaries ages 11 and older. Because these providers can obtain vaccines at no cost through the Vaccines for Children (VFC) program, only the administration fee is reimbursable for vaccines administered to adolescents. Pharmacy providers that have not been selected to participate in the VFC program are not eligible to administer vaccines to beneficiaries under age 19.
MSA 15-07	5/1/2015	School Based Services	Section 11 – Audit and Recovery Procedures (new subsection)	Addition of new section.
			11.1 Direct Service/ Transportation Program Audit Activities to be Performed by MDHHS Office of Audit Staff (new subsection)	New subsection text reads: MDHHS audit review of selected ISD/DPS and MSD cost reports for the Direct Service/Transportation Program may include the following activities: • Verification that the Medicaid Allowable Expenditure Report (MAER) accurately reports the allowable costs incurred for the appropriate period. • Verification that the salaries listed for employees/positions included in the RMTS staff pool match the payroll records for the same period as the time study. • A review of the salaries of employees who changed positions during the time study period. • If a replacement was hired/transferred, the auditor will verify that only the salary earned while working in a position on the MAER staff pool list was reported, and that salaries for both the original and replacement employees were not duplicated on the report for the same time period. • Confirmation that none of the direct costs reported were also claimed as an indirect cost, that the proper indirect cost rate was used, and the rate was applied only to costs in the base. The employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation

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				will be reviewed for these individuals. • Verification that no federal funds were claimed on MAER cost reports and that MAER costs were not accepted for cost-sharing. • A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts should also be expected. • Any other area deemed necessary. The ISD/DPS/MSD should be prepared to direct the auditor to any document used to support and identify the reported MAER costs.
			11.2 Student Claims Audit Activities to be Performed by MDHHS Office of Audit Staff (new subsection)	New subsection text reads: MDHHS audit review of selected ISD/DPS and MSD for approved SBS student claims may include the following activities: • Verification that appropriate prescriptions/referrals/authorizations are updated annually and ordered by the appropriate individual. • Verification that occupational, physical, and speech, language and hearing therapy address a beneficiary's medical need that affects his/her ability to learn in the classroom environment. • Confirmation that services requiring the student to be in attendance have support documentation (i.e., attendance records) on file. • Confirmation that the providers performing the service have the required licensure/certification. • Verification that the providers requiring supervision both "under the direction of" and "under the supervision of" have the necessary support documentation on file.

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				• Verification that the beneficiary receiving special education transportation also received a Medicaid-covered service on the same day. In addition, the support documentation for specialized transportation includes an ongoing trip log maintained by the provider of the special education transportation. • Confirmation that support documentation for personal care services includes a completed, signed and dated monthly activity checklist. • Verification that group therapy or treatment was provided in groups of two to eight. • A standard review of the Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP) treatment plan areas, such as the inclusion of a description of the beneficiary's qualifying diagnosis and medical condition, time-related goals that are measurable and significant to the beneficiary's function and/or mobility, and anticipated frequency and duration of treatment required to meet the time-related goals. • Any other area deemed necessary. The ISD/DPS/MSD should be prepared to direct the auditor to any document used to support and identify the reported student claims.
			11.3 Audit Activities to be Performed by MDHHS Office of Audit Staff (new subsection)	Subsection text was relocated from the School Based Services Administrative Outreach Program Claims Development chapter, 2.7 Audit Activities to be Performed by MDHHS Office of Audit Staff.

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			11.4 Audit Findings and Resolution (new subsection)	New subsection text reads: Audit findings and resolution will include the following: • Identified overstatement of expenditures on the MAER will require the revision of the MAER and a revised final settlement for all specifically identified overstatements. • For claim error rates in excess of the materiality threshold percentage, as established by MDHHS, the recovery will be any excess percentage greater than materiality threshold multiplied by total Medicaid paid to the ISD during the period covered by the audit. Recoveries and re-filings are limited to fiscal years considered within three years from the last date of payment for that period.
		School Based Services Administrative Outreach Program Claims Development	2.7 Audit Activities to be Performed by MDHHS Office of Audit Staff	Subsection was deleted. Subsection text was relocated to the School Based Services chapter, 11.3 Audit Activities to be Performed by MDHHS Office of Audit Staff. The following subsections were re-numbered.
MSA 14-61	12/1/2014	Practitioner Reimbursement Appendix	Section 3 – Primary Care Provider Rate Increase	The following text/burst box was added: Effective January 1, 2015, the provisions of this section are no longer in effect. Refer to the Primary Care Practitioner Services Incentive Payment section for additional information.
			Section 4 – Primary Care Practitioner Services Incentive Payment (new section)	New section text reads: For dates of service on and after January 1, 2015, MDHHS applies an increased payment rate to enrolled providers for primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The increase applies to a set of designated primary care services.

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			4.1 Provider Eligibility (new subsection)	New subsection text reads: Physicians with primary specialty designations of family medicine, general internal medicine, and pediatric medicine may qualify as primary care practitioners for purposes of increased payment. Eligibility for this payment is limited to being board certified or board eligible in one of the three designated primary care specialties as recognized by the American Board of Medical Specialties, American Osteopathic Association, and the American Board of Physician Specialists. Primary care physicians may also be determined eligible by conducting a thorough review of the physician's practice characteristics as identified through their billing history. Physician practitioners whose CHAMPS Provider Enrollment profile information reflects that they provide specialty or subspecialty (e.g., cardiology, endocrinology, or oncology, etc.) services are not eligible for the adjusted payment. Providers with multiple subspecialties are also not eligible for the adjusted payment. Exceptions will be made for practitioners who have subspecialty practices in adolescent and geriatric medicine. Before enhanced payments are made, MDHHS will verify that a practitioner meets the eligibility criteria which are identified as the following: • Board Certification: A primary care physician who has designated their primary specialty in their CHAMPS enrollment file as one of the three eligible specialties and has provided applicable Board certification information will be validated by MDHHS prior to any enhanced payment. • Board Eligible: A primary care physician who has designated their primary specialty in their CHAMPS enrollment file as one of the three eligible specialties and has provided applicable documentation to support board eligibility status is also eligible for the enhanced payment. MDHHS will recognize physicians as board eligible for the period of time as defined by the applicable medical board following completion of their medical residency training program in one of the defined specialties.

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				• Review of Practice Characteristics: For non-board certified or non-board eligible primary care physicians, MDHHS will review an enrolled practitioner's billing history for the previous calendar year. At least 60 percent of the physician's codes paid by Medicaid must be for the evaluation and management (E/M) codes specified in this policy, including the preventive medicine E/M codes. This review of practice characteristics will be done by MDHHS only for providers who have self-attested by designating in their CHAMPS enrollment file that their primary specialty is one of the three eligible specialties. • Non-physician Practitioners: Nurse practitioners (NPs) and physician assistants (PAs) who provide primary care services under the personal supervision of a physician who is one of the designated primary care specialty types may be reimbursed at the enhanced rate. Claims submitted by NPs and PAs must include their own NPI as the rendering provider and the NPI of their supervising/delegating physician. If the NP's or PA's supervising/delegating physician has not been identified as an eligible provider for the primary care rate, as verified by CHAMPS enrollment, services performed by the NP or PA will not receive the enhanced rate. Practitioners delivering primary care services at Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Local Health Departments (LHDs) are not eligible for these enhanced payments. Practitioner services in these settings are reimbursed using a payment methodology designed to reimburse those providers at cost and are made on a facility basis, not specific to the physician's services. Practitioners who participate in the MDHHS Physician Adjustor Program are eligible for the primary care provider rate increase. For these participating providers, MDHHS calculates the Physician Adjustor Program payment adjustment consistent with the existing methodology. Physicians with primary specialty designations of family medicine, general internal medicine, and pediatric medicine who are affiliated with Medicaid Health Plans (MHP) are eligible for the primary care practitioner rate increase as identified by their Primary

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				Care Provider status within the MHP network.
			4.2 Eligible Primary Care Services (new subsection)	New subsection text reads: Primary care practitioner services subject to the enhanced primary care rate are defined as Healthcare Common Procedure Coding System (HCPCS) codes: • 99201 through 99215 for new and established patient office or outpatient evaluation and management (E/M) visits • 99304 through 99318 for initial, subsequent, discharge and other nursing facility E/M services • 99324 through 99337 for new and established patient domiciliary, rest home or custodial care E/M services • 99341 through 99350 for new and established patient home E/M visits • 99381 through 99397 for new and established patient preventive medicine services
			4.3 Enhanced Rates for Primary Care (new subsection)	New subsection text reads: For primary care practitioners identified as eligible for the primary care rate, payment will be made on the qualified procedure codes as published in a separate fee schedule as published on the MDHHS website. The Primary Care Fee Schedule reflects rates that have been adjusted in compliance with funding levels established by state law. (Refer to the Directory Appendix for website information.)
MSA 14-09	2/28/2014	School Based Services	2.11 Special Education Transportation	Addition of the following text: **Taxi and Private Vehicle Transportation** For a taxi or family vehicle transportation expense to be reimbursed, the following documentation must be on file at the local education agency (LEA) or intermediate school district (ISD): • Specialized transportation must be included in the Individualized Education

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				Program (IEP). • A Medicaid covered medical service must be provided on the same day as the transportation. • Dates and times of each trip must be listed on the LEA's or ISD's trip log. • Documentation from the beneficiary's physician or a school provider treating the student, stating the reason taxi or family transportation is required must be retained in the student's file. • For transportation by taxi, an additional statement justifying the need for a taxi and the reason other less costly means of transportation cannot be used must be retained in the student's file. • For ongoing transportation needs, documentation is only required once per student per school year. • For one-time or occasional use transportation, documentation is required for each trip, or trip period per beneficiary. • The total number of trips claimed for taxi and family transportation must be included in the Special Education trip count on the Medicaid Allowable Expenditure Report (MAER). Taxi and family vehicle cost reimbursement will be retroactive to July 1, 2012 if the proper documentation has been retained, and a claim for the trip has been approved through the Community Health Automated Medicaid Processing System (CHAMPS). Claims must be filed within one year from the date of service according to Medicaid timely filing requirements. Transportation by stretcher car is not covered. The term "stretcher car" is defined as a vehicle capable of transporting a patient (student) in a prone or supine position (e.g., Ambucab).

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		Acronym Appendix		Addition of: MAER – Medicaid Allowable Expenditure Report
MSA 13-22	7/1/2013	Nursing Facility Cost Reporting & Reimbursement Appendix	8.8 Interest	The 6th bullet was revised to read: Working capital borrowings are considered funds borrowed for a relatively short time period of 12 months or less to meet current normal operating expenses. For lines of credit, the borrowing shall be compliant with the 12 month requirement if the provider repays the entire amount withdrawn within 12 months of the date of the first draw. ➢ The loan must meet allowable cost principles. The rules on working capital borrowings do not apply to loans on capitalized assets. Interest on current indebtedness meeting the 12 month requirement and other program working capital criteria is allowable, whereas interest expense for long-term working capital indebtedness is not considered allowable. ➢ The nursing facility must document the need and due date for the working capital loan. The need must be to meet normal operating expenses and must be supported by an application of funds analysis demonstrating the use of loan proceeds for nursing facility expenses. ➢ For the application of funds analysis, the provider must show that current cash receipts are not sufficient to meet the accounts payable, payroll, and other financial obligations. The provider must also demonstrate that the loan proceeds went directly into the appropriate cash account. The provider must document when each withdrawal was used, how each withdrawal was used, and how the funds are being applied to a purpose related to patient care. If the Home Office is the recipient of funds and intends to transfer funds to a provider under the Home Office, the provider must demonstrate the financial need for the funds, how the money was used, and how the use is related to patient care.

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				➢ The loan must include/require repayment of the principal balance within a prescribed time period, including regular scheduled repayment amounts applying to the principal borrowings amount. The provider may repay the principal balance of the loan on a monthly, quarterly, or annual basis. If the provider repays the entire principal balance before the expiration of the loan term, the interest expense on that loan is considered allowable. If the provider has a line of credit, the provider must repay the entire amount withdrawn within 12 months of the date of the first draw for the interest expense to be considered allowable.

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