MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 14-06

Distribution: All Providers

Issued: February 27, 2014

Subject: Updates to the Medicaid Provider Manual; ICD-10 Project Update; and Document Management Portal in CHAMPS

Effective: As Indicated

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

Updates to the Medicaid Provider Manual

The Michigan Department of Community Health (MDCH) has completed the April 2014 update of the online version of the Medicaid Provider Manual. The manual is located 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

MDCH continues to transition its policies, procedures and information systems to support the ICD-10 code sets on all Health Insurance Portability and Accountability Act (HIPAA) transactions by the federally mandated compliance date of October 1, 2014.

As part of this process, testing activities have begun to include Outpatient Medical Scenario Testing as well as Business to Business (B2B) Testing. MDCH offers Medicaid providers and trading partners an opportunity to test their ability to communicate with MDCH using ICD-10 coded transactions. The testing is designed to help providers ensure that their remediation efforts to prepare for the implementation of ICD-10 coding have resulted in the creation of transactions that can be successfully processed. Additionally, the ICD-10 Awareness and Training Team continue to conduct ICD-10 Awareness Training in Basic ICD-10. Please check the MDCH website for more detailed information at www.michigan.gov/5010ICD10 (click on "ICD-10 Information", and scroll to "MDCH Links").

Document Management Portal in CHAMPS

The Document Management Portal (DMP) is now accessible for all Community Health Automated Medicaid Processing System (CHAMPS) users. This tool will enable providers and billers to electronically submit supporting documentation for Medicaid electronic claims, e.g., submit consent forms or records requested for Predictive Modeling requirements. DMP is an alternative to uploading documents through the EZlink portal. Information and tutorials on the DMP 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
Medical Services Administration

Michigan Department of Community Health

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April 2014 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Revisions were made to the listed Benefit Plans: CSHCS = addition of Service Type Code 71 CSHCS-MC = addition of Service Type Code 71 HK-EXP = addition of Service Type Codes 71, MH HK-EXP-ESO = addition of Service Type Codes 1, 47, 48, 50, 88, 91, 92, MH, UC with the statement (Emergency Services Only) MA = addition of Service Type Codes 71, MH MA-ESO = addition of Service Type Codes 1, 47, 48, 50, 88, 91, 92, MH, UC with the statement (Emergency Services Only) MA-MC = addition of Service Type Codes 71, MH MIChild = addition of Service Type Codes 71, MH MME-MC = addition of Service Type Codes 71, MH PACE = addition of Service Type Code 71 TMA-PLUS = addition of Service Type Codes 71, MH	Updates.
Beneficiary Eligibility	9.1 Enrollment	Under "Voluntary Enrollment", the 2nd bullet point was revised to read: Native American Indians	For consistency in wording.
Beneficiary Eligibility	12.2.A. Nursing Facility Determinations	The 6th paragraph was revised to read: ..., it indicates a tentative patient pay amount to be collected by the facility. In determining the tentative patient pay amount, DHS does not prorate for partial months. This amount is...	Clarification.
Coordination of Benefits	2.6.G. Exceptions to the Billing Limitation	The 1st sentence was revised to read: ...if the provider can document that Medicare was billed within 120 days of the date of service and Medicaid was billed within 120 days of the date of payment, rejection or retroactive recovery of funds by Medicare.	Clarification.

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

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	4.1 Authorization of Admissions and Services	In the 1st paragraph, the 3rd bullet point was revised to read: ...If a beneficiary is admitted for medical/surgical services authorized by the health plan and needs psychiatric consultation or care, the initial mental health assessment will be the responsibility of the health plan. The PIHP/CMHSP must be contacted for authorization of subsequent psychiatric services and is then responsible for payment for the psychiatric services.	Incorporation of information released in Letter L 10-21.
Billing & Reimbursement for Institutional Providers	6.2.J. Patient-Pay Amount	The 4th bullet point was deleted.	Information is no longer relevant.
Billing & Reimbursement for Institutional Providers	11.1 Billing Instructions for Hospice Claim Completion	The 3rd bullet point was revised to read: **Core Based Statistical Area (CBSA):** "Value Codes" - include value code 61 in the value code field and report the CBSA number. Hospice claims must ...	Change needed to comply with current billing practices. CBSA codes are only five digits. If two zeroes are added by the provider, payment is zero.
Adult Benefits Waiver	Table of Contents	The following burst was added to the Table of Contents: **Effective April 1, 2014, the Adult Benefits Waiver has ended. All beneficiaries enrolled in the Adult Benefits Waiver have been transitioned to the Healthy Michigan Plan.**	
Children's Special Health Care Services	Section 8 – Coverage Period	The following text was added as a 5th paragraph: All coverage periods end on the last day of a month, or the client's 21st birthday if the client does not have a qualifying diagnosis that is covered beyond age 21.	Text was relocated from 8.1 Medical Renewal Period as it applies to all, and not just medical renewal, periods.

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CHAPTER	SECTION	CHANGE	COMMENT
Children's Special Health Care Services	8.1 Medical Renewal Period	The 5th paragraph was deleted.	Text was relocated to Section 8 - Coverage Period as it applies to all, and not just medical renewal, periods.
Dental	4.3 Other Sites	The 2nd paragraph was revised to read: It is the expectation that services provided by all mobile operators/facilities will follow appropriate protocol with regard to infection control, portable equipment and standard of care.	Clarification.
Dental	6.2.C. Sealants	The 1st and 2nd paragraphs were revised to read: Coverage is limited to fully erupted permanent first and second molars (2, 3, 14, 15, 18, 19, 30, 31) for children ages 5 through 15 for the prevention of pit and fissure caries. Conditions required for coverage include: • Surfaces must be free from caries. • Surfaces to be sealed must be free of any restorations.	Wording correction for clarification.
Dental	6.4.A. Root Canal Therapy	The 3rd paragraph was revised to read: The root canal therapy is not covered if the following conditions exist: • Furcation pathology is present. • A posterior tooth has no opposing tooth. • Tooth is not restorable under Medicaid guidelines.	Wording correction for clarification.

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Dental	8.2. B. Crown and Bridge Services	Subsection was renamed: Specialty Crown and Bridge Services Subsection text was revised in its entirety to read: Qualification for specialty crown and bridge services is based on the specific diagnoses and treatment plan. Not all CSHCS beneficiaries will qualify for specialty crown and bridge services. Crowns and bridges: • Require prior authorization. • Will not be replaced within five years of the insertion date. Refer to the Children's Special Health Care Services chapter for additional information on specialty dental benefits.	Clarification.
Hospital	5.1 Home Help	The 3rd sentence was revised to read: Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination (excluding the combination of Home Help and MI Choice Waiver services) as defined in Medicaid policy.	Clarification.
Hospital Reimbursement Appendix	1.5 Payment Calculation	The following text was added as a 3rd paragraph: For claims when a provider bills charges less than the OPPS/APC amount for non-fee schedule items, the MDCH payment liability is the APC amount minus any Medicare or other insurance payments up to the coinsurance, copayment, and/or deductible amount reported.	Clarification.
Medical Supplier	1.5 Medical Necessity	The following text was added as the 4th paragraph: MDCH does not cover the service when Medicare determines that the service is not medically necessary.	Clarification.

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Nursing Facility Coverages	5.1.B. Correct/Timely Preadmission Screening/Annual Resident Review (PASARR)	The 3rd paragraph was revised to read: Placement options for Medicaid beneficiaries who are determined through Level II Preadmission screening to have (1) a mental illness or (2) an intellectual disability, or a condition related to mental illness or intellectual disability are determined through the federal PASARR screening process requirements.	Clarify the role of PASARR in determining eligibility for MA beneficiaries. Also, the phrase mental retardation is antiquated; the accepted language is now 'intellectual disability'.
Directory Appendix	Policy/Forms/ Publications	Under "Health & Human Services", the website address was revised to read: http://www.hhs.gov/opa/order-publications/#pub_sterilization-pubs	Update.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 14-02	1/30/2014	Nursing Facility Cost Reporting & Reimbursement Appendix	8.28.D. Penalty Taxes Under the Patient Protection and Affordable Care Act (new subsection)	New subsection text reads: Penalty taxes that may be assessed on employers under the employer-shared responsibility provisions in the Patient Protection and Affordable Care Act (PPACA) are not allowable costs used to calculate the Medicaid room and board rate. As such, the facility must remove these penalty taxes from allowable costs via a Worksheet 1-B adjustment.
		Acronym Appendix		Addition of: PPACA - Patient Protection and Affordable Care Act
MSA 14-01	1/30/2014	Hospice	3.4.B. Nursing Facility	In the 6th paragraph, the 1st sentence was revised to read: ...(including a beneficiary for whom a complex care authorization has been approved) or in a Ventilator Dependent Care Unit (VDCU).
		Hospice	7.3.I. Hospice-Owned Nursing Facility	Subsection was deleted. Following subsections were re-numbered.
		Nursing Facility Cost Reporting & Reimbursement Appendix	10.12.C. Hospice-Owned/ -Operated Nursing Facility	Subsection was deleted. Following subsections were re-numbered.
MSA 13-52	12/23/2013	Hospice	7.3.A. Rate Methodology	The following text was added as the 2nd sentence: Medicaid Fee for Service hospice providers who have not submitted required quality data to the Centers for Medicare & Medicaid Services (CMS) in compliance with the Hospice Quality Reporting Program (HQRP) will receive reduced reimbursement.
MSA 13-51	12/23/2013	Dental	8.2 Covered Services and General Prior Authorization Information	The 3rd paragraph was deleted.

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			8.2.A. Orthodontic Services	Subsection text was revised in its entirety to read: Orthodontic treatment is covered for CSHCS clients who have a qualifying dental diagnosis that includes orthodontia. It is the responsibility of the provider to verify CSHCS eligibility prior to rendering services. **NOTE: CSHCS coverage ends at age 21. Services completed after the client's 21st birthday will not be reimbursed.** Information regarding CSHCS medical eligibility criteria and qualifying diagnoses for specialty dental services can be found in the Children's Special Health Care Services chapter. Refer to the Dental database on the MDCH website for procedure codes and age limits for each stage of interceptive treatment. (Refer to the Directory Appendix for website information.) Prior authorization (PA) is required for each phase of orthodontic treatment, including interceptive, comprehensive, and continued care. PA requests for orthodontic services must be submitted on the Dental Prior Approval Authorization Request form (MSA-1680-B). PA requests must be approved prior to the placement of bands. Requests submitted after the initiation may result in the denial of the PA request or non-payment of services. The following documentation must be included with each completed MSA-1680-B as applicable to each phase of treatment: • Tooth chart documenting teeth present/absent • A complete orthodontic treatment plan • Proposed surgery • Expected timeframe for completion of treatment • Radiographs (cephalometric, panoramic, full series) • Optional: Intraoral and facial photographs (not reimbursed by Medicaid)

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			8.2.A.1. Pre-Orthodontic Treatment Visit (new subsection)	New subsection text reads: The pre-orthodontic treatment visit includes the examination and diagnostic casts. Radiographs (full mouth series, cephalometric, panoramic) are reimbursed separately from the evaluation. The pre-orthodontic treatment visit does not require prior authorization (PA).
			8.2.A.2. Interceptive Orthodontic Treatment (new subsection)	New subsection text reads: Interceptive orthodontic treatment is considered intervention in the early stages of a developing problem. It must be completed during the appropriate developmental stage for success. The treatment must be deemed necessary to lessen the severity or prevent future effects of a malformation and may involve non-surgical appliances used for palatal expansion. Interceptive orthodontic treatment is a one-time PA request for the entire time period of treatment. Early phases of comprehensive treatment are not considered interceptive treatment. A single claim is submitted for the entire interceptive treatment phase. The banding/start date is the Date of Service (DOS), and the PA number must be included on the claim. Reimbursement is made for the entire treatment time period and is considered payment in full.
			8.2.A.3. Comprehensive Orthodontic Treatment (new subsection)	New subsection text reads: Comprehensive orthodontic treatment codes are used when multiple phases of treatment are provided at different stages of orofacial development. Comprehensive orthodontic treatment services are covered for a lifetime maximum of six years, with each phase of treatment covered for up to two years. There is an initial reimbursement for each stage, with a maximum allowable amount within the two year period. The submission of the first PA request for comprehensive orthodontic treatment should list the appropriate procedure code and the banding/start date of treatment.

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				Comprehensive orthodontic procedure codes are used in the first stage of each comprehensive treatment phase. The DOS is the banding insertion date, and the PA number must be included on the claim. An initial payment is made with a claim submission using the comprehensive orthodontic procedure code and the banding insertion date as the DOS. Subsequent payments are made bi-annually using the periodic orthodontic treatment procedure code.
			8.2.A.4. Periodic Orthodontic Treatment (new subsection)	New subsection text reads: Periodic orthodontic treatment requires PA. For each six-month time period, a new PA request must be approved prior to the continuation of treatment. To facilitate timely approval, it is recommended that PA requests for periodic orthodontic treatment be submitted 30 days prior to the desired start date of the treatment period. For each additional six-month time period, a separate PA request for a periodic orthodontic treatment visit must be submitted, including the periodic treatment code and description of service. In addition, the start date of the entire stage of orthodontic treatment should be included. The periodic orthodontic treatment procedure code may be used up to a maximum of four times per comprehensive orthodontic treatment. This information is necessary for reviewing case histories and verifying the payment status of the client. No additional PA will be approved if the provider has received the maximum allowable reimbursement for treatment. When billing the periodic orthodontic treatment visit, the DOS is the first day of the six-month treatment period. The DOS cannot be the same as the banding insertion date. The beginning and end dates for the entire time period should be entered in the Remarks Section of the claim form. The PA number must be included on the claim.

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				Periodic orthodontic treatment is reimbursed based on a six-month time period. If treatment ends prior to the completion of the six-month time period, the provider pro-rates the charges according to the treatment time frame (e.g., if only three months are needed to complete treatment, the charges should reflect half of the current periodic orthodontic treatment fee). When paid reimbursement to the provider has met the maximum allowable for the specific phase of treatment, no additional reimbursement will be made and the case is considered paid in full.
			8.2.A.5. Debanding/ Retention (new subsection)	New subsection text reads: Debanding and retention are considered part of the interceptive and comprehensive orthodontic treatment phases and are included in the reimbursement rate. Replacement of lost or broken retainers is allowed twice per lifetime per client.
MSA 13-50	12/23/2013	Hospital Reimbursement Appendix	7.9 Rural Access Pool (new subsection)	New subsection text reads: The Rural Access Pool (RAP) is a pool for hospitals that provide Medicaid services to low-income rural residents and will be created and renewed annually. To be eligible for this pool, hospitals must be categorized by CMS as a sole community hospital, or meet both of the following criteria: • A hospital must have 50 or fewer staffed beds. MDCH will calculate staffed beds by dividing the total hospital days reported by the hospital on its Medicaid cost report with a FY ending between October 1, 2010 and September 30, 2011 by the number of days covered in the cost report; and

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				• A hospital must be located in a county with a population of not more than 165,000 and within a city, village, or township with a population of not more than 12,000. The population threshold will be measured against population counts from the 2000 federal decennial census. Each hospital's allocation from this pool will be calculated as the unreimbursed cost the hospital incurred providing inpatient and outpatient services to Michigan Medicaid beneficiaries during its cost period that ended during the second previous FY. (Example: To calculate the FY 2014 pool, hospital cost reports with FYs ending between 10/1/2011 and 9/30/2012 will be used.) The following gross Medicaid payments from this cost report period will be applied against cost to determine unreimbursed costs: operating, capital, graduate medical education (GME), executive order reductions, and Medicaid Access to Care Initiative (MACI). Payments from this pool will be issued quarterly in four equal installments based on the total amount the hospital is eligible to receive. In the aggregate, MDCH will reimburse hospitals up to the maximum allowable under the federal upper payment limits for inpatient and outpatient services provided to Medicaid beneficiaries. To keep total Medicaid Fee-For-Service payments to hospitals within the federal upper payment limits, MDCH will reduce the size of the corresponding FY MACI pool each year by the amount of the RAP. Payments made from the RAP will be applied against hospitals' inpatient and outpatient settlement limits. Funds paid in excess of these limits will be recovered during settlement, and the federal share returned to the federal government.
MSA 13-46	11/26/2013	Beneficiary Eligibility	9.1 Enrollment	Under "Excluded Enrollment", the last bullet point was revised to read: People receiving Private Duty Nursing Services. All beneficiaries enrolled in a health plan will be disenrolled retroactively to the first day of the month in which the PDN services are received.

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		Beneficiary Eligibility	9.7 Excluded Health Plan Services	The following text was inserted/added as the 10th bullet point: Drugs in the categories listed on the MHP carve-out list are excluded from the MHP contract. (Refer to the Directory Appendix for website information.) The 10th (11th) bullet point was revised to read: Private Duty Nursing (PDN) services.
		Billing & Reimbursement for Professionals	5.2 Ongoing Services and Extended Treatment Plans	In the 1st paragraph, text after the 2nd sentence was revised to read: ...Enrollment in a health plan always triggers an authorization process. There is no requirement for a new health plan to reimburse providers for services that were authorized under a previous health plan with an exception for CSHCS/Medicaid beneficiaries with a Prior Authorization (PA) in place at the time of enrollment in the current health plan. In order to preserve continuity of care, MHPs and Fee-For-Service (FFS) must accept PAs in place when the CSHCS/Medicaid beneficiary has a change in enrollment status. For CSHCS/Medicaid beneficiaries who have been in the FFS system and who have FFS PA in place at the time the MHP receives the enrollment file, MHPs are expected to honor the PA in place for 30 days after the effective date of enrollment. Full reciprocity is required between the party that originally authorized the service and the new payer for the first 30 days following the enrollment change. This includes accepting the approved provider, services, quantity limits, Medicaid rates and special rates, as well as other terms that have been negotiated for the beneficiary's care. • The servicing provider is responsible for transmitting a copy of the previously approved PA to the new payer when there is a change in the beneficiary's enrollment status. • If the prior authorized provider is not in the MHP network, the MHP must pay the out-of-network provider at the prior authorized rate for the first 30 days following the enrollment change. Providers may not bill FFS or the beneficiary for services covered by the MHP; the provider must bill the MHP.

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				• Providers must be enrolled with Medicaid to bill FFS. Providers may not bill the MHP or the beneficiary for services covered by Medicaid FFS; the provider must bill FFS. For all other purposes, the health plan in which the beneficiary is enrolled must assess the need for continuing services and authorize as appropriate. Health plans should facilitate the transition between providers for all beneficiaries to ensure continuity of care.
		Directory Appendix	Health Plan Information	Addition of: Contact/Topic: Medicaid Health Plan Carve-Out Mailing/E-Mail/Web Address: https://michigan.fhsc.com >> Providers >> Drug Information >> Medicaid Health Plan Carveout Information Available/Purpose: Drugs in the categories listed on the MHP carve-out list are excluded from the MHP contract.
MSA 13-44	12/2/2013	General Information for Providers	11.2.A. Beneficiaries Excluded from Copayment Requirements	In the 1st paragraph, the following bullet points were added: • Native American Indians/Alaska Natives • Enrollees in the Breast and Cervical Cancer Control Program (BCCCP)
		Beneficiary Eligibility	9.9 Copayments	The following text was added at the end of the 1st paragraph: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.
		Adult Benefits Waiver	1.5 Copayment	The following text was added at the end of the 1st paragraph: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.

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		Chiropractor	1.2 Beneficiary Copayment	The following text was added at the end of the 1st paragraph: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.
		Dental	Section 3 - Copayment	The following text was added at the end of the 1st paragraph: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.
		Federally Qualified Health Centers	4.5 Copayments	The following text was added at the end of the 1st paragraph: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.
		Hearing Aid Dealers	1.6 Copayments	The following text was added at the end of the 1st paragraph: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.
		Hospital	1.4 Copayments	The following text was added at the end of the 1st paragraph: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.
		Nursing Facility Coverages	10.26.D.1. Beneficiary Liability Under Medicare Part D	The following text was added at the end of the 1st paragraph: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.
		Pharmacy	1.7 Medicaid Health Plans and ABW County Health Plans	In the table after the 3rd paragraph, the following text was added under "Copayment": Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.

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		Pharmacy	13.6.A. Medicaid Copayments	The following text was added at the end of the 1st paragraph: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.
		Practitioner	1.3 Copayments	The following text was added at the end of the 1st paragraph: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.
			23.1 Copayment	The following text was added at the end of the paragraph: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.
		Rural Health Clinics	6.6 Copayments	The following text was added at the end of the paragraph: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.
		Special Programs	2.1.A. Eligible Beneficiaries	The following text was added as the 3rd sentence in the 1st paragraph: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.
		Tribal Health Centers	7.4 Copayments	The 1st paragraph was revised to read: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.
		Urgent Care Centers	4.1 Copay Requirements	The following text was added at the end of the 1st paragraph: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.

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		Vision	1.1 Beneficiary Eligibility and Copayments	The following text was inserted after the 2nd paragraph: NOTE: Native American Indians/Alaska Natives and enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays.
MSA 13-43	11/26/2013	General Information for Providers	6.1 Termination or Denial of Enrollment	The following bullet point was added to the 2nd paragraph: • Failure to comply with Medicaid policies regarding billing Medicaid beneficiaries.
		Coordination of Benefits	Section 1 - Introduction	The following text was deleted from the end of the 2nd paragraph: If MDCH finds after a claim is adjudicated that another payer was liable for the service, a claim adjustment will be processed. The provider will then have to bill the identified third party resource for the service.
			1.1 Subrogation	Subsection text was revised in its entirety to read: As a condition of Medicaid eligibility, beneficiaries must assign MDCH the right to seek recovery of other resource payments made on their behalf. If MDCH identifies another resource for a paid claim, a bill will be generated to the other resource within the appropriate timely filing guideline. The other resource will reimburse Medicaid directly or reject the paid claim. MDCH will review other resource rejections to determine if the rejection is appropriate or if the provider can resubmit the claim to the other resource for reimbursement.
			1.2 Claim Void Process (new subsection; following subsection was re-numbered)	New subsection text reads: 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. MDCH will automatically void the claim after the 30 days if no adjustment is made.

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				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.
MSA 13-42	11/26/2013	Laboratory	5.5 Genetic and Molecular Testing (new subsection)	New subsection text reads: The following standards of coverage and prior authorization and documentation requirements apply to beneficiaries served by Fee-for-Service Medicaid. For beneficiaries enrolled in a Medicaid Health Plan, the provider must check with the beneficiary's Plan for coverage and prior authorization requirements.
			5.5.A. Standards of Coverage (new subsection)	New subsection text reads: Whenever possible, Michigan Medicaid follows Medicare guidelines. Medicare does not cover a genetic test for a clinically affected individual for purposes of medical research, family planning, disease risk assessment of other family members or when the treatment and surveillance of the beneficiary will not be affected, or in any other circumstance that does not directly affect the diagnosis or treatment of the beneficiary. Genetic testing **is** considered a covered benefit when it is medically necessary to establish a molecular diagnosis and treatment of a genetic disease and all of the following are met: • The testing must be ordered by a physician (MD or DO) who is an enrolled provider. • The beneficiary has documented clinical features symptomatic of a condition or disease, or is at risk of inheriting the disease based upon personal history, family history, documentation of a genetic mutation and/or ethnic background. • Following history, physical examination, pedigree analysis, and completion of conventional diagnostic testing, a definitive diagnosis remains uncertain and a genetic diagnosis is suspected. • The test results will be used to significantly alter the management or treatment of the disease. • If applicable, the testing method is an FDA-approved method for the identification of a specific genetically-linked inheritable disease as evidenced by the following measures:

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				➢ The genotypes to be detected by a genetic test must be shown, by scientifically valid methods, to be associated with the occurrence of the disease; ➢ The analytical and clinical validity of the test must be established; ➢ The observations must be independently replicated and subject to peer review; and ➢ The clinical testing laboratory must be an enrolled provider who is properly certified by CLIA. Testing is allowed once during the beneficiary's lifetime per disease for diagnostic purposes. If medically necessary, and on a case-by-case basis, prior authorization may be requested to allow for exceptions to this restriction. Providers must follow state law (Public Act 368 of 1978, Section 333.17020 Genetic test; informed consent) regarding informed consent for predictive genetic testing. This includes any statutory requirements for pre- or post-testing genetic counseling. There must be made available, upon request, documentation of pre-testing informed consent provided before testing. This documentation must include the limitations of the test, possible outcomes, and methods for communicating and maintaining confidentiality of results. Genetic testing **is not** considered a covered benefit for: • Criteria other than those outlined above. • Testing to confirm a diagnosis or disorder that can be diagnosed by conventional diagnostic methods. • Testing for conditions or purposes where the test results would not directly influence the management or treatment of the disease or condition (e.g., a disease without known treatment). • Testing for informational purposes or management of a beneficiary's family member. • Confirmatory testing for validation of laboratory results. • Screening for investigational or research purposes.

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				• Minors under the age of 18 for adult onset conditions that have no preventative or therapeutic treatments. • Testing that has not been performed in a CLIA-certified laboratory. • The sole purpose of family planning counseling and infertility services.
			5.5.B. Prior Authorization Requirements and Documentation (new subsection)	New subsection text reads: For genetic testing that requires prior authorization, the following documentation must be submitted prior to the testing being performed: • Indication for the test. • Clinical notes that clearly detail the beneficiary's related signs and symptoms, including relevant family history. A family pedigree analysis must be made available upon request. • Other related testing or clinical findings of the beneficiary or family member. • Documentation supporting that the test results will be used to significantly alter the management or treatment of the disease. • The name and NPI number of the laboratory performing the test.

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