MDHHS Michigan Department of Health & Human Services

Health and Aging Services Administration

BULLETIN

HASA

Bulletin Number: HASA 22-07

Distribution: All Providers

Issued: March 1, 2022

Subject: Updates to the Medicaid Provider Manual

Effective: April 1, 2022

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Children's Waiver, Maternity Outpatient Medical Services, MI Choice Waiver

The Michigan Department of Health and Human Services (MDHHS) has completed the April 2022 update of the online version of the MDHHS Medicaid Provider Manual. The manual will be available April 1, 2022, at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider 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, Letters & 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.

Manual Maintenance

If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms, this bulletin and those referenced in this bulletin may be discarded. If using a CD version of the MDHHS Medicaid Provider Manual, providers should retain all bulletins issued since the version date of the CD. Providers are encouraged to use the MDHHS 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, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit questions, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 1-800-292-2550. Atypical Providers may phone toll-free 1-800-979-4662.

Approved

Kate Massey, Director
Health and Aging Services Administration

Michigan Department of Health and Human Services

Medicaid Provider Manual
April 2022 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	1.4 ListServ Communications	Text was revised to read: The MDHHS ~~Medical Services Administration (MSA)~~ Health and Aging Services Administration (HASA) offers individuals the option of receiving automated announcements regarding the Michigan Medicaid Program (i.e., changes to policy, billing issues, training opportunities, etc.) through subscription to an e-mail listserv. Subscription instructions are posted on the MDHHS website. (Refer to the Directory Appendix for website information.)	Reflects recent revisions to organization of MDHHS.
General Information for Providers	2.3.E. Home Help – Personal Choice and Acknowledgement of Provider Selection	The subsection was removed in its entirety.	The policy is specific to the Home Help program and was moved to the new Home Help chapter.
General Information for Providers	6.1 Termination or Denial of Enrollment	The following note was added to the end of the subsection: **NOTE**: Individual Home Help providers denied enrollment due to certain program exclusions may still provide services through the Personal Choice and Acknowledgement of Provider Selection process. (Refer to the Providers [Prohibited Providers] Section of the Home Help chapter for more information.)	The note replaces Section 2.3.E. of this chapter and refers the reader to the new location of the policy.
Beneficiary Eligibility	1.1 Local Michigan Department of Health and Human Services Office Determination	The textbox after the 1st paragraph was revised to read: The MDHHS ~~Medical Services Administration (MSA)~~ Health and Aging Services Administration (HASA) determines eligibility for Children's Special Health Care Services (CSHCS).	Reflects recent revisions to organization of MDHHS.

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

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Addition of: Benefit Plan ID: CTS Benefit Plan Name: Community Transition Services Benefit Plan Description: Community transition services (CTS) are Medicaid funded services provided to qualified individuals who currently reside in a nursing facility, hospital, or other institution and have expressed a desire to return to the community, but who have barriers to a discharge that cannot be met by discharge staff. CTS may also be provided to individuals in the community who previously transitioned and are at risk for going back to the nursing facility or other institution. Type: Fee for Service Funding Source: XIX Covered Services: TC	Update.
Beneficiary Eligibility	Section 10 – Children's Special Health Care Services	The 1st paragraph was revised to read: ~~The~~ MDHHS ~~Medical Services Administration (MSA)~~ HASA determines eligibility for the CSHCS Program. CSHCS provides medically necessary services to individuals who are eligible and apply under the following circumstances:	Reflects recent revisions to organization of MDHHS.
Beneficiary Eligibility	12.1.C. State-Owned and -Operated Facilities/PIHPs/CMHSPs	Text was revised to read: ~~MSA~~ HASA or the PIHP/CMHSP determines a financial liability, or ability to pay, separate from the MDHHS patient pay amount. The ability to pay may be an individual, spouse, or parental responsibility. It is determined and reviewed as required by the Mental Health Code. The beneficiary or his authorized representative is responsible for the ability to pay amount, even if the patient pay amount is greater.	Reflects recent revisions to organization of MDHHS.

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CHAPTER	SECTION	CHANGE	COMMENT
Coordination of Benefits	1.3 Verification of Other Insurance	Text was revised to read: Information about a beneficiary's other insurance is available through the CHAMPS Eligibility Inquiry and/or vendor that receives eligibility data from the CHAMPS 270/271 transaction. It is not displayed on the **mihealth** card. (Refer to the Beneficiary Eligibility Chapter for additional information.) Providers should always ask the beneficiary if other insurance coverage exists at the time of service. If the beneficiary identifies other insurance coverage that is not listed in the eligibility response, the provider must use that other insurance and report it to MDHHS by contacting Medicaid Provider Inquiry or by completing the on-line Request to Add, Terminate, or Change Other Insurance (form DCH-0078) ~~the Third Party Liability Section~~. If the beneficiary belongs to a network, the provider must refer him to that preferred provider for services needed. (Refer to the Directory Appendix for contact information.) If the beneficiary does not agree with the other insurance information contained in the eligibility response~~,~~ (e.g., other insurance coverage is no longer available), the beneficiary should be instructed to notify his local MDHHS office of the change or contact the Beneficiary Helpline to report the change. If the provider elects to initiate a change to the beneficiary eligibility response, the ~~Request to Add, Terminate, or Change Other Insurance (form~~ DCH-0078~~)~~ should be completed. (Refer to the Forms Appendix for a copy of the form and additional instructions.) The form should be submitted prior to billing Medicaid. If known, providers should include the policy's per diem payment amount or any supplemental information in the comments section of the form. The TPL Section will verify the information provided and update the beneficiary's CHAMPS eligibility information accordingly. The provider should bill the other resource first. Once payment has been received, the provider may bill Medicaid. The Medicaid claim must include the payment amount received from the other resource.	

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Dental Providers	5.6.A. Interceptive Orthodontic Treatment	The subsection title was revised to read: ~~Interceptive~~ Limited Orthodontic Treatment The 1st sentence was revised to read: For ~~interceptive~~ limited orthodontic treatment, submit a single claim for the entire ~~interceptive~~ limited treatment phase.	Wording change due to procedure code deletion.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	Under "Team Composition and Size", the 2nd paragraph in the first column was revised to read: *The average number of visits per day/week/month/etc. provided by the whole team, not individual ACT team members, to ~~an individual~~ a consumer will comprise 80% of home or community contacts. This average is for the entire team, an average across the entire caseload (not individual consumers) and is to be based on medical necessity.* In the 2nd paragraph, the last bullet point was revised to read: • If the ACT team provides substance use disorder services, there must be a designated Substance Abuse Treatment Specialist who has one or more credentials through the Michigan Certification Board of Addiction Professionals (MCBAP). If the ACT team provides co-occurring treatment or substance use disorder treatment, the organization must have a substance use disorder treatment license issued by the State of Michigan, if applicable, based on state licensing requirements and as outlined in contract.	Additional detail added to improve clarity of service description.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 14 – Children's Home and Community-Based Services Waiver (CWP)	The 2nd paragraph was removed: ~~The Children's Waiver is a fee-for-service program administered by the CMHSP. The CMHSP will be held financially responsible for any costs incurred on behalf of the CWP beneficiary that were authorized by the CMHSP and exceed the Medicaid fee screens or amount, duration and scope parameters.~~	Removed outdated references to fee-for-service contracts.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	15.1 Waiver Supports and Services	Under "Community Living Supports (CLS)", the 3rd and 4th paragraphs were revised to read: For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADL~~s~~, and/or shopping may be used to complement Home Help ~~or Expanded Home Help~~ services when ~~the individual's needs for this assistance have been officially determined to exceed DHS's allowable parameters~~ MDHHS has determined the individual's need for this assistance exceeds Home Help service limits. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help ~~or Expanded Home Help~~. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings. If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADL~~s~~, and/or shopping, the beneficiary must request Home Help ~~and, if necessary, Expanded Home Help~~ from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help ~~or Expanded Home Help~~. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision.	Removed references to Expanded Home Help to achieve consistency with the Home Help chapter of the manual.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.B. Community Living Supports	In the 3rd paragraph, 1st bullet point, 2nd paragraph, text was revised to read: CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or state plan services, e.g., Personal Care (assistance with ADL~~s~~ in a certified specialized residential setting) and Home Help ~~or Expanded Home Help~~ (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help ~~and, if necessary, Expanded Home Help~~ from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help ~~or Expanded Home Help~~. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment. The 5th paragraph was revised to read: CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help ~~or Expanded Home Help~~ services when ~~the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters~~ MDHHS has determined the individual's need for this assistance exceeds Home Help service limits. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help ~~or Expanded Home Help~~.	Removed references to Expanded Home Help to achieve consistency with the Home Help chapter of the manual.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.G.4. Youth Peer Support Services	Text was revised to read: Youth Peer Support is a peer-delivered service for youth and young adults. It is designed to support youth and young adults with a serious emotional disturbance/serious mental illness (SED/SMI) through shared activities and interventions in the form of ~~direct support, information-sharing and skill-building~~ non-judgmental support, connection through lived experience and supporting self-advocacy. This service supports youth and young adult voice as part of the Family-Driven, Youth-Guided/Person-Centered approach to treatment and occurs as part of the treatment process. The goals of Youth Peer Support include supporting youth and young adults in their mental health journey by building a strong relationship based on mutual respect and strategic self-disclosure to increase hope, confidence, self-advocacy skills, and decision-making abilities. ~~Youth Peer Support Services are provided by trained youth peer support specialists, one-on-one, for youth with SED and young adults with SMI.~~ Youth Peer Support is a relationship-based service that focuses on supporting youth and young adult empowerment by connecting to the emotions related to living with mental health challenges as a youth or young adult. It is not intended to substitute for other services such as respite, community living support services, or transition-specific support services. Youth Peer Support Specialists must have direct lived experience ~~navigating behavioral health systems and must participate in and complete the approved MDHHS training curriculum~~ with mental health challenges as a youth. Youth Peer Support activities are identified as part of the assessment and the person-centered/family-driven, youth-guided planning process. The goals of Youth Peer Support services shall be included in the individualized plan of service where interventions are provided in the home and community. These goals, to support the youth or young adult's mental health, will be mutually identified in active collaboration with the youth or young adult receiving services and must be delivered by a Youth Peer Support Specialist with lived experience.	The changes outlined are intended to clarify the role and function of Youth Peer Support Specialists who provide the Youth Peer Support service.

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CHAPTER	SECTION	CHANGE	COMMENT
		Youth Peer Support is intended to be provided to children, youth, and young adults who are middle school to 26 years of age. It is not intended to substitute for other services such as respite or community living support services. The Youth Peer Support Specialist shall receive regular supervision by a child mental health professional and shall participate as an active member of the treatment team. ~~Qualified Staff~~ Youth Peer Support Specialists must have lived experience navigating behavioral health systems and must actively participate in and complete the approved MDHHS ~~core training and~~ curriculum, ongoing certification, and recertification requirements ~~and expectations~~. Qualifications for the Youth Peer Support Specialist include: • Young adult, ages 18 through 28, with lived experience with mental health challenges as a youth ~~or young adult~~ and who received mental health support as a youth or young adult. • Willing and able to self-identify as a person who has received or is receiving behavioral health services and is prepared to use that experience in helping others. • Experience receiving services in a variety of systems (such as child welfare, education, the justice system, vocation, housing, etc.) as a youth or young adult is preferred. • Employed by PIHP/CMHSP or its contract providers. • Trained in the MDHHS approved curriculum and ongoing ~~training~~ certification and recertification model.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	19.3.C. OHH Benefit Plan Assignment	Text was revised to read: Once enrolled, the beneficiary is assigned to the Opioid Health Home ~~(HHO)~~ (OHH) benefit plan associated with their Medicaid member ID in the Community Health Automated Medicaid Processing System (CHAMPS). It is incumbent upon OHH providers to verify a beneficiary's ~~HHO~~ OHH benefit plan assignment prior to rendering services. Beneficiaries without the ~~HHO~~ OHH benefit plan assignment are not eligible for OHH payment.	For consistency, made the acronym for Opioid Health Home "OHH" in all instances.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix	Section 1 – General Information	Text was revised to read: The Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW) Program provides services that are enhancements or additions to Medicaid state plan coverage for children up to age 21 with serious emotional disturbance (SED) who are enrolled in the SEDW. MDHHS operates the SEDW through managed care contracts. ~~with the CMHSPs. The SEDW is a fee-for-service program administered by the CMHSP in partnership with other community agencies. The CMSHP will be held financially responsible for any costs authorized by the CMHSP and incurred on behalf of a SEDW beneficiary.~~	Removed outdated references to fee-for-service contracts.
Behavioral Health and Intellectual and Developmental Disability Supports and Services Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix	Section 3 – Medicaid State Plan Services	The 1st and 2nd paragraphs were revised to read: In addition to SEDW services, children served by the SEDW have access to Medicaid Mental Health State Plan services (e.g., psychotherapy, medication management, OT and PT evaluations, home based services) ~~provided by their CMHSP on a fee-for-service basis~~. Services that can be billed to Medicaid are listed on the MDHHS CMHSP Serious Emotional Disturbance (SED) Waiver Database which is available on the MDHHS website. The database lists the CPT/HCPCS code, modifiers (when applicable), short description, Medicaid fee screen, and applicable quantity/timeframe parameters for each service. (Refer to the Directory Appendix for website information.) Transportation is a Mental Health State Plan service ~~covered under a number of HCPCS codes, only one of which can be billed fee-for-service for children on the SEDW~~. Parameters related to this service for SEDW enrollees are identified.	Removed outdated references to fee-for-service contracts.

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CHAPTER	SECTION	CHANGE	COMMENT
Community Transition Services	3.5 Home and Community-Based Services Personal Care	The 2nd paragraph was revised to read: HCBS Personal Care Services provided while in the community are limited to beneficiaries who are not eligible for State Plan Personal Care Services (~~Adult~~ Home Help) or who require personal care services to begin before State Plan Personal Care Services or other HCBS services (e.g., Program of All-Inclusive Care for the Elderly [PACE], MI Health Link, MI Choice) can be authorized. Beneficiaries must not receive both State Plan Personal Care Services and HCBS Personal Care Services at the same time. HCBS Personal Care Services may also be authorized when a beneficiary's needs change and they are unable to quickly secure other personal care services available through the State Plan or a waiver. Services cannot duplicate, replace or supplant other available State Plan services. Beneficiaries enrolled in another HCBS program offering similar services must receive personal care services through that program	Home Help services are available to Medicaid beneficiaries under the age of 18.
Dental	8.2.A. Orthodontic Services	The 3rdaragraph was revised to read: PA is required for each phase of orthodontic treatment, including ~~interceptive~~ limited, comprehensive, and continued care. PA requests for orthodontic services must be submitted on the MSA-1680-B. PA requests must be approved prior to the initiation of any treatment. An MSA-1680-B submitted after the initiation of services will be denied, resulting in non-payment of services. The MSA-1680-B requesting orthodontic treatment is approved for a six-month time period.	Wording change due to procedure code deletion.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	8.2.A.2. Interceptive Orthodontic Treatment	The subsection title was revised to read: ~~Interceptive~~ Limited Orthodontic Treatment Text was revised to read: ~~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 reduce the severity or prevent future effects of a malformation and may involve non-surgical appliances used for palatal expansion. ~~Interceptive~~ Limited 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.~~	Word changes and deletions due to procedure code deletion.
Dental	8.2.A.5. Debanding/ Retention	Text was revised to read: Debanding and retention are considered part of the ~~interceptive~~ limited and comprehensive orthodontic treatment phases and are included in the reimbursement rate. Replacement of lost or broken retainers is allowed twice per lifetime per beneficiary.	Word change due to procedure code deletion.
Healthy Michigan Plan Policy and Operational Process Document: Identification of Medically Frail Beneficiaries		Under "Retrospective Claims Analysis", in the 1st paragraph, Item "b." was revised to read: b. Whether a beneficiary is in a nursing home or hospice or is receiving services through the ~~Adult~~ Home Help program or Children's Special Health Care Services program.	Home Help services are available to Medicaid beneficiaries under the age of 18.

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CHAPTER	SECTION	CHANGE	COMMENT
Home Health	11.1 Home Help Program	Text was revised to read: The Home Help Program provides unskilled personal care services (i.e., assistance with ADL~~s~~, IADL~~s~~, and complex care tasks) ~~and other services allowed by the Home Help Program~~ to assist eligible beneficiaries ~~who are blind, disabled, or otherwise functionally limited~~ with functional limitation(s) resulting from a medical or physical disability or cognitive impairment. The beneficiary's adult services worker at the local MDHHS office ~~arranges for these services with the personal care provider.~~ issues a provider-specific service authorization that includes the list of tasks the personal care provider is authorized to furnish to the client. (Refer to the Providers [Provider Payments] Section of the Home Help chapter for more information.) The Home Health POC must clearly identify why the HHA services are required along with Home Help. Medicaid covers occasional follow-up HHA visits made to observe, evaluate and document the beneficiary's progress if ordered by the attending physician.	The list of tasks eligible for Home Help payment has been replaced with the broader categories of "ADL", "IADL" and "complex care tasks" to ensure consistency in the description of Home Help services throughout the manual. The definition of eligible beneficiaries has been revised to align with the definition in the Home Help chapter.
Hospice	6.10 Home Help/ Personal Care	The 1st paragraph was revised to read: Home Help~~/personal care~~ services may be available to the hospice beneficiary living at home (e.g., not residing in a hospice residence, NF, AFC, etc.). It is important that hospice services be utilized first, prior to Home Help services. Home Help services may be in addition to hospice care and must not duplicate hospice services. Home Help~~/personal care~~ services ~~are~~ include assistance with ~~eating, toileting, bathing, grooming, dressing, transferring, self-administered medication, meal preparation, shopping/errands, laundry and light housekeeping~~ ADL, IADL, and complex care tasks. Some examples of when these services are appropriate are: … The burst box below the 1st paragraph was revised to read: If hospice services duplicate or replace personal care services, payment is not approved for Home Help~~/personal care~~.	To ensure a consistent description of Home Help services throughout the manual, the phrase "/Personal Care" has been removed and the list of tasks eligible for Home Help payment has been replaced with the broader categories of "ADL", "IADL" and "complex care tasks".

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.18 Injections/ Intravenous Infusions	The 1st paragraph was revised to read: MDHHS covers intramuscular, subcutaneous or intravenous injections and intravenous (IV) infusions when medically necessary. In the inpatient hospital, reimbursement is included in the DRG payment. In the outpatient hospital (OPH) or Ambulatory Surgical Center (ASC), reimbursement generally follows CMS Outpatient Prospective Payment System (OPPS) guidelines. Injectables paid differently than CMS OPPS are listed on the MDHHS OPPS Wraparound Code List for OPH or ASC. (Refer to the Directory Appendix for website information.)	Add text previously removed in error.
Hospital	5.1 Home Help	Text was revised to read: The beneficiary is able to remain in his own home. Home Help providers ~~perform unskilled household and personal care tasks that the beneficiary cannot do himself.~~ assist the beneficiary with activities of daily living (ADL), instrumental activities of daily living (IADL), and complex care tasks. 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.	The list of tasks eligible for Home Help payment has been revised to ensure consistency in the description of Home Help services throughout the manual.
Hospital Reimbursement Appendix	2.3.A.6. Special Circumstances	Under "Hospitals Outside Michigan", the 2nd paragraph was revised to read: Hospitals that have charges that exceed $250,000 during a single fiscal year (using the State of Michigan fiscal year – October 1st through September 30th) may be reimbursed the hospital's inpatient operating cost to charge ratio for those Michigan Medicaid DRGs reimbursed by percentage of charge. The hospital's chief financial officer must submit, and ~~the MSA~~ Health and Aging Services Administration (HASA) must accept, documentation stating the hospital's Medicaid cost to charge ratio in the state that the hospital is located. Once accepted, the hospital's actual cost to charge ratio is applied prospectively to those DRGs and claims subject to percentage of charge reimbursement using the Michigan DRG payment system.	Reflects recent revisions to organization of MDHHS.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	2.3.B.3. New LTACHs, Freestanding Rehabilitation Hospitals, and Distinct Part Rehabilitation Units	The 1st paragraph was revised to read: If a hospital at least doubles the number of licensed beds in its distinct part unit and the number of licensed beds in the units increases by at least 20, the entire unit is treated as a new distinct part unit for determining the per diem rate. In order for this provision to apply, the hospital must request, in writing, that the unit is treated as a new unit. The new unit rate will become effective on the date that the number of licensed beds doubles and the increase is at least 20 beds, or the date on which the request is received by ~~MSA~~ HASA, whichever is later.	Reflects recent revisions to organization of MDHHS.
Hospital Reimbursement Appendix	7.6.E. Allocation of Pools	Text was revised to read: MACI distributions are made prospectively based on historical data. Eligible hospitals will share proportionately from each pool based upon a hospital's total paid claims ~~(inpatient)/Medicaid Cost Report payments (outpatient),~~ divided by the total Medicaid paid claims~~/MMS payments~~ for all eligible hospitals, times the dollar amount of the individual pool. If a hospital closes or is determined ineligible to receive distributions from a pool, its MACI distribution will be redistributed to the remaining eligible hospitals based on the original distribution formula. In the event the MACI distributions would result in aggregate Medicaid payments exceeding the UPL, the size of the pool(s) will be reduced to bring the aggregate Medicaid payments within the UPL.	Section was missed during incorporation of MSA 15-62
Maternal Infant Health Program	5.3 Operations and Certification Requirements	The last bullet point was revised to read: • Follow all Medicaid policies as published in the ~~Michigan~~ MDHHS Medicaid Provider Manual, ~~Medical Services Administration~~ Health and Aging Services Administration (HASA) Bulletins, and the Maternal Infant Health Program Operations Guide.	Reflects recent revisions to organization of MDHHS.

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Medicaid Provider Manual
April 2022 Updates

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CHAPTER	SECTION	CHANGE	COMMENT
Non-Emergency Medical Transportation	Section 4 – Transportation Provider Qualifications	The last paragraph was reformatted and revised to read: Beneficiaries who transport themselves or individuals providing NEMT services to a Medicaid-enrolled family member will not be required to enroll in CHAMPS and will be exempted from mandated provider screening requirements. Self-attestation is sufficient when determining the familial relationship between the driver and the Medicaid beneficiary. Foster parents who transport their foster children are not required to enroll in CHAMPS and are exempt from mandated provider screening requirements. ~~Demand-responsive~~ Public ~~transit services~~ transportation providers (demand response and fixed route) and commercially hailed or street taxicabs are also exempt from CHAMPS enrollment and screening requirements. These providers and their drivers presumptively meet the criteria to provide transportation for Medicaid beneficiaries as they are licensed or registered through the appropriate state authority (e.g., Secretary of State, Licensing and Regulatory Affairs, Michigan Department of Transportation) or equivalent(s) in the state in which they are operating.	Clarifying that both public transit types are excluded from CHAMPS enrollment. Omission of fixed route was unintentional. This change will follow current practice.

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CHAPTER	SECTION	CHANGE	COMMENT
Non-Emergency Medical Transportation	4.4 Commercial and Nonprofit Providers	Text was revised to read: The minimum requirements for commercial and nonprofit providers are: ▪ 18 years of age and older; ▪ Must be able to read and communicate effectively in English; ▪ Valid driver's license appropriate to the class of vehicle being operated; ▪ Compliant with Sections 304 and 319 of the Michigan Vehicle Code related to restricted drivers licenses as issued by the Michigan Secretary of State (MDHHS reserves the right to deny or revoke enrollment of a provider due to a restricted or suspended license); ▪ Maintenance of all necessary licensure and certification required by all transportation public laws, ordinances, and regulations applicable to the transportation provider, including any that may require liability insurance; ▪ Compliant with the Americans with Disabilities Act (ADA) of 1990, as amended; ▪ Operation of vehicles that meet the safety and medical needs of the beneficiary; ▪ Compliant with any state or federal statutes applicable to commercial and nonprofit transportation providers; ▪ Compliant with all applicable confidentiality laws as required by the Medicaid program; and ▪ Compliant with ~~all provider enrollment background and screening requirements as required by the Medicaid program. (Refer to~~ the General Information for Providers Chapter of this manual. ~~for additional information.)~~ NOTE: Taxicab carriers are exempt from CHAMPS enrollment and screening requirements.	Confirming that taxicab carriers and their drivers do not have to enroll in CHAMPS, as mentioned in the beginning of Section 4. This additional language will clarify why they are not required to enroll.

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CHAPTER	SECTION	CHANGE	COMMENT
Non-Emergency Medical Transportation	4.5 Public Transportation Providers	Text was revised to read: The minimum requirements for public transportation providers are: ▪ 18 years of age and older; ▪ Must be able to read and communicate effectively in English; ▪ Commercial Driver's License (CDL) if operating a vehicle having a gross vehicle weight of 26,001 pounds or more, or designed to transport 16 or more people (including driver); ▪ Compliant with Michigan state statutes: Michigan Motor Bus Transportation Act of 1990, as amended; Michigan Motor Carrier Safety Act of 1963, as amended; and Michigan Vehicle Code, as amended; ▪ Compliant with the Americans with Disabilities Act (ADA) of 1990, as amended; ▪ Operation of vehicles that meet the safety and medical needs of the beneficiary; ▪ Compliant with all applicable confidentiality laws as required by the Medicaid program; and ▪ Compliant with ~~all provider enrollment background and screening requirements as required by the Medicaid program. (Refer to~~ the General Information for Providers Chapter of this manual. ~~for additional information.)~~ **NOTE:** Public transit services (demand response and fixed route) are exempt from CHAMPS enrollment and screening requirements.	Clarifying that there are no enrollment background and screening requirements by the Medicaid program for these providers. Removing these sentences will clarify policy.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Non-Emergency Medical Transportation	5.2 Meals	The 3rd paragraph was revised to read: Meal reimbursement requires ~~original,~~ itemized, unaltered receipts which must include the business name, address, date, time, and itemized list of items purchased with cost of each item. However, if the restaurant or place of business omits any necessary items from their receipt, the information may be hand-written by the individual incurring that expense.	Change is due to MSA 20-68. This bulletin was already incorporated in the NEMT chapter, but this section was missed for changes.
Nursing Facility Certification, Survey & Enforcement Appendix	Section 1 – Introduction	The 2nd paragraph was revised to read: As required by federal law, the State Medicaid Agency (MDHHS~~, Medical Services Administration~~ Health and Aging Services Administration [HASA]) has entered into an interagency agreement with the State Survey Agency (Michigan Department of Licensing and Regulatory Affairs [LARA], Bureau of Community and Health Systems [BCHS]) to conduct surveys of Medicaid providers and applicants. The State Medicaid Agency (SMA) accepts State Survey Agency (SSA) certification decisions as final, but exercises its own determination whether to enter into agreements with providers.	Reflects recent revisions to organization of MDHHS.
Nursing Facility Certification, Survey & Enforcement Appendix	2.3 Criteria for Evaluation of Medicaid Bed Certification Applications	The 1st paragraph was revised to read: The SMA (MDHHS-~~MSA~~ HASA) will collaborate with the SSA (LARA-BCHS) when making a determination regarding the approval or denial of any application for Medicaid bed certification and provider enrollment. Approval or denial of an application to MDHHS for Medicaid bed certifications will be based on the following criteria:	Reflects recent revisions to organization of MDHHS.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Certification, Survey & Enforcement Appendix	2.4.C. Bed Certification Process During a Change in Ownership (CHOW)	The 1st paragraph was revised to read: A provider seeking a change in ownership of a nursing facility must first receive approval through the CON process within MDHHS. The new provider can avoid a delay in payment and address any potential certification issues by submitting a written 90-day advance notice, plus a copy of the sale and/or lease agreement, to the SSA, the SMA/~~LTC Services~~ Long Term Care Policy Section and RARSS. (Refer to the Directory Appendix for contact information.) The 4th paragraph was revised to read: If the new owner wants to change the bed certifications, a written application must be filed with the SSA and with the SMA/Long Term Care ~~Services~~ Policy Section. The SMA and the SSA will collaborate regarding the consideration and disposition of the application for changes in the Medicaid bed certifications. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification Applications subsection.	Reflects recent revisions to organization of MDHHS.
Nursing Facility Certification, Survey & Enforcement Appendix	2.8 Nursing Facility Closure Protocol	Text was revised to read: An interagency agreement exists~~, including the SMA, the Aging and Adult Services Agency (AASA), the SSA, and~~ between MDHHS and LARA~~,~~ to delineate the roles and responsibilities of the respective agencies when residents of licensed/certified nursing facilities must be relocated due to nursing facility involuntary or voluntary closure. The agreement applies to all nursing facilities, including those that are county medical care facilities or hospital long-term care units. At the time of a closure, the nursing facility will be provided with a copy of this agreement and contact information for the agency representatives who will be involved in the closure.	Reflects recent revisions to organization of MDHHS.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Certification, Survey & Enforcement Appendix	2.9 Voluntary Withdrawal From Participation in the Medicaid Program or Voluntary Nursing Facility Closure	In the 2nd paragraph, the 2nd bullet point was revised to read: • State Medicaid Agency (SMA) /Long Term Care ~~(LTC) Services~~ Policy Section, The 5th and 6th paragraphs were revised to read: 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~~ Long Term Care Policy 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~~ Long Term Care Policy 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 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.	Reflects recent revisions to organization of MDHHS.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 1 – Introduction	The 2nd paragraph was revised to read: Throughout the appendix, references will be made to the State Medicaid Agency (SMA) and the State Survey Agency (SSA). The Michigan Department of Health and Human Services (MDHHS), ~~Medical Services Administration~~ Health and Aging Services Administration (HASA), is the designated SMA, and is responsible for administration of the Medicaid program. The Michigan Department of Licensing and Regulatory Affairs (LARA), Bureau of Community and Health Systems (BCHS) is the designated SSA.	Reflects recent revisions to organization of MDHHS.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 2 – Definitions	The definition for "State Medicaid Agency (SMA)" was revised to read: The Michigan Department of Health and Human Services (MDHHS). The work unit within MDHHS with administrative responsibility for the Medical Assistance (Medicaid) Program is the ~~Medical Services Administration~~ Health and Aging Services Administration (HASA).	Reflects recent revisions to organization of MDHHS.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.13.F. Facility Innovative Design Supplemental (FIDS) Program	The 2nd paragraph was revised to read: The FIDS facility standards and required culture change must be maintained throughout the Medicaid supplemental payment program. FIDS participating facilities will be reviewed annually by ~~the Aging and Adult Services Agency (AASA)~~ HASA to certify continued participation in the culture change. Reimbursement of the FIDS payment will be terminated if it is determined that a facility is not compliant with the culture change requirement. FIDS participating nursing facilities receive increased capital reimbursement for FIDS construction and renovation projects. The increased reimbursement is paid through the claims reimbursement process. Reimbursement of the supplement amount is contingent upon sufficient appropriation to the Medicaid budget.	Reflects recent revisions to organization of MDHHS.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	10.13.F.1. Change of Ownership	Text was revised to read: A new owner may receive reimbursement for the balance of the facility's eligible years of participation in the FIDS program. The new owner must notify RARSS via File Transfer within 45 calendar days of the change of ownership if the facility is going to continue participation in the FIDS program, or RARSS will assume participation has been discontinued and end FIDS reimbursement supplemental payments. In order to receive the supplemental Medicaid payment, the new owner must continue the FIDS facility standards and culture change. If the new owner initially decides to discontinue participation as a FIDS facility and subsequently decides to participate as a FIDS facility, the provider must notify the LARA, Bureau of Community and Health Systems (BCHS) team manager and ~~AASA~~ HASA. MDHHS will notify the provider of the supplemental payment amount upon reinstatement of participation in FIDS. MDHHS will notify the provider of the terminated supplemental payment if the facility is determined ineligible for the supplemental payment because the new owner has discontinued or plans to discontinue the FIDS facility standards or culture change.	Reflects recent revisions to organization of MDHHS.
Pharmacy	Section 5 – Signature Log, Data Collection and Documentation	The following text was added as a burst box: NOTE: The requirements in the following subsection are waived in accordance with Letter L 20-20 beginning March 26, 2020 and until MDHHS issues policy notifying providers of their termination.	Added for clarification.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	5.1.B. Proof of Delivery	Subsection was removed in its entirety. ~~Pharmacy providers must maintain a log verifying proof of delivery for all prescriptions delivered by common carrier (i.e., FedEx, UPS, USPS, etc.). Pharmacies should be able to link the tracking information to the prescription record through supporting documents if requested. Pharmacies must validate the member's address prior to mailing the prescription. A tracking number alone is not considered a valid proof of member receipt. The tracking number must be accompanied by either:~~ ~~• the manual or electronic signature of the member or their representative at the time of delivery; or~~ ~~• the tracking detail from the carrier showing medication was delivered, including date and time of delivery.~~	Rescinded until replaced with promulgated language.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	1.10 Services in a Teaching Setting	The 3rd and 4th paragraphs were revised to read: Guidelines require the presence of the teaching physician during the key portion of the performance of the service in which a resident is involved and the teaching physician seeks payment (or the hospital on the behalf of the physician). The medical record must fully support the physician's presence and participation in the service provided. There are exceptions and other considerations that may apply; therefore, the full text of the guidelines must be consulted to ensure compliance. ~~Any services that meet the teaching physician criteria must be reported with the appropriate modifier.~~ CMS provides an exception to the physician presence requirement for some low- and mid-level Evaluation and Management (E/M) services furnished ~~in certain primary care centers~~ within a teaching setting when specified conditions are met. For Medicaid, the preventive medicine E/M visits are also included under the ~~"presence"~~ primary care exception for primary care services provided ~~in the primary care centers~~ by residents. Under the CMS primary care exception, time cannot be used to select a visit level, only medical decision making (MDM). The appropriate modifier must be reported using the ~~"presence"~~ primary care exception when residents provide E/M services. The E/M services that can be reported with this modifier include office or other outpatient visits requiring straightforward or low-complexity medical decision making and comprehensive preventive medicine visits. For higher-level services and all invasive procedures, the teaching physician must be present.	Clarification.
Practitioner	3.4 Care of Abuse Children	The 1st paragraph was revised to read: Medicaid covers physician services related to the diagnosis and treatment of suspected abused or neglected children. When the physician has reasonable cause to suspect that a child may have been abused or neglected, he must immediately contact the appropriate Protective Services Unit of the local ~~DHS~~ MDHHS office to report his suspicions.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	6.1.D. Cost Reconciliation and Settlement	The 5th paragraph was revised to read: Within six months after the close of the school fiscal year, ~~the~~ School Based Services providers will review, certify, and finalize the MAER and transmit the report to the MDHHS ~~Medical Services Administration~~ Health and Aging Services Administration (HASA) for reconciliation. The cost certification form (CMS-10231; Certification of Public Expenditures) must be signed and on file with MDHHS before a final settlement will be processed. The final settlement process will begin within 12-18 months after the close of the school fiscal year. Settlements may take several months for completion. (Refer to the Forms Appendix for a copy of the CMS-10231.)	Reflects recent revisions to organization of MDHHS.
Acronym Appendix		The following acronyms were added: HASA – Health and Aging Services Administration The following acronyms were removed: ~~AASA – Aging and Adult Services Agency~~ ~~MSA – Medical Services Administration~~	Reflects recent revisions to organization of MDHHS.
Acronym Appendix		Addition of: MDM – medical decision making	
Directory Appendix	Appeals	Under "Appeals/Administrative Hearings (Provider)", the web address was revised to read: http://www.michigan.gov/lara >> Bureau List >> Michigan Office of Administrative Hearings and Rules >> Administrative Rules >> Publications >> Michigan Administrative Code >> Select Department: Health and Human Services >> ~~Medical Services~~ Health and Aging Services Administration >> ~~MSA~~ HASA Provider Hearings	Reflects recent revisions to organization of MDHHS.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Appeals	Under "Appeals/Administrative Hearings/Informal Conferences (Provider)", the web address was revised to read: http://www.michigan.gov/lara >> Bureau List >> Michigan Office of Administrative Hearings and Rules >> Administrative Rules >> Publications >> Michigan Administrative Code >> Select Department: Health and Human Services >> ~~Medical Services~~ Health and Aging Services Administration >> ~~MSA~~ HASA Provider Hearings	Reflects recent revisions to organization of MDHHS.
Directory Appendix	Provider Resources	Addition of: Contact/Topic: Michigan Automated Prescription System (MAPS) Mailing/Email/Web Address: www.michigan.gov/mimapsinfo Information Available/Purpose: Michigan's prescription drug monitoring program. MAPS is used to identify and prevent drug diversion at the prescriber, pharmacy, and patient level.	Added information for prescribers.
Directory Appendix	MI Health Link	Under "Medicaid State Plan Personal Care Services Payment Schedule", text under "Information Available/Purpose" was revised to read: Table indicating the minimum schedule when payments should be made for personal care services during the MI Health Link continuity of care period for individuals who were receiving ~~Adult~~ Home Help services through MDHHS.	Home Help services are available to Medicaid beneficiaries under the age of 18.
Directory Appendix	Nursing Facility Resources	Under "Pre-Eligibility Medical Expenses (PEME)", the mailing address was revised to read: MDHHS ~~Medical Services~~ Health and Aging Services Administration Attention: PEME PO Box 30479 Lansing, MI 48909-9634	Reflects recent revisions to organization of MDHHS.

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CHAPTER	SECTION	CHANGE	COMMENT
Forms Appendix		The following forms were revised to reflect recent revisions to the organization of MDHHS, i.e., "Medical Services Administration" was revised to read "Health and Aging Services Administration": • MSA-1302; Benefits Monitoring Program Referral • MSA-1550; Beneficiary Verification of Coverage • MSA-4240; Certification for Induced Abortion • MSA-1653-D; Complex Seating and Mobility Device Prior Approval – Request/Authorization • MSA-2081; Genetic and Molecular Laboratory Test Authorization Request • MSA-181; Home Health Aide Prior Approval Request/Authorization • MSA-1755; Medicaid Enrolled Birthing Hospital Agreement for Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation • MSA-6544-B; Practitioner Special Services Prior Approval – Request/Authorization • MSA-0732; Private Duty Nursing Prior Authorization – Request for Service • MSA-1653-B; Special Services Prior Approval – Request/Authorization	Reflects recent revisions to organization of MDHHS.
Forms Appendix	MSA-1580; Request for Authorization of Private Room Supplemental Payment for Nursing Facility	"Long Term Care Services" was revised to read "Long Term Care Policy Section".	Reflects recent revisions to organization of MDHHS.
Forms Appendix		Forms were revised to reflect an update to the MDHHS Non-Discrimination Statement.	Update.
Forms Appendix	DCH-0078; Request to Add, Terminate or Change Other Insurance	In the address on page 1 of the form, "Bureau of Medicaid Operations" was changed to "Bureau of Medicaid Policy, Operations & Actuarial Services".	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Forms Appendix	MSA-2565-C; Hospital Newborn Notice	On page 2, under "Patient Certification, text was revised to read "… the facility named in section ~~9~~ 11 above, …".	Correction.

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Medicaid Provider Manual
April 2022 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 21-19	7/2/2021	Behavioral Health and Intellectual and Developmental Disability Supports and Services	12.1 Covered Services – Outpatient Care	The subsection title was revised to read: ~~Covered Services –~~ Outpatient Care
			12.2 Medication-Assisted Treatment (MAT) (new subsection)	New subsection text reads: Medication-Assisted Treatment (MAT) is the use of medications often used in combination with counseling and behavioral therapies to provide a whole-patient approach to the treatment of substance use disorders (SUDs). Medications used in MAT are approved by the Food and Drug Administration (FDA). MAT programs are clinically driven and tailored to meet each patient's needs. MAT is a covered service for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service. The State assures coverage of Naltrexone, Buprenorphine, and Methadone and all the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262). The State also provides coverage for additional MAT drugs per the Michigan Preferred Drug List (PDL) used by the Fee for Service (FFS) pharmacy program. This is described as the Single PDL. (Refer to the Directory Appendix for Michigan Preferred Drug List website information.) The State assures that Methadone for MAT is provided by Opioid Treatment Programs (OTPs) that meet the requirements in 42 C.F.R. Part 8.
			12.2.A. MAT Methadone Within OTPs (new subsection title)	New title to reflect re-organization of subsection.
			12.2.A. Provision of Services	The subsection was re-numbered as 12.2.A.1.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			12.2.B. Covered Services	The subsection was re-numbered as 12.2.A.2.
			12.2.C. Eligibility Criteria	The subsection was re-numbered as 12.2.A.3.
			12.2.D. Admission Criteria	The subsection was re-numbered as 12.2.A.4. The subsection title was revised to read: ~~Admission Criteria~~ Continuum of Care
			12.2.D.1. Special Circumstances for Admissions	The subsection title was eliminated; and text was relocated to be a part of 12.2.A.4. Continuum of Care.
			12.2.E. Medical Maintenance Phase	The subsection title was eliminated; and text was relocated to be a part of 12.2.A.4. Continuum of Care.
			12.2.F. Discontinuation/ Termination Criteria	The subsection title was eliminated; and text was relocated to be a part of 12.2.A.4. Continuum of Care.
			12.2.F.1. Completion of Treatment	The subsection title was eliminated; and text was relocated to be a part of 12.2.A.4. Continuum of Care.
			12.2.F.2. Administrative Discontinuation	The subsection title was eliminated; and text was relocated to be a part of 12.2.A.4. Continuum of Care.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			12.3 Primary Care Office-Based Alcohol Treatment (OBAT)/Office-Based Opioid Treatment (OBOT) (new subsection; the following subsections were re-numbered)	New subsection text reads: Primary care providers who do not have a specialty substance use disorder (SUD) benefit services contract with the PIHP are permitted to seek fee for service (FFS) reimbursement for alcohol use disorder (AUD) and opioid use disorder (OUD) services in an office-based setting. (Refer to the Office-Based Alcohol Treatment (OBAT)/Office-Based Opioid Treatment (OBOT) subsection in the Practitioner chapter for additional information regarding reimbursement provision.)
		Behavioral Health and Intellectual and Developmental Disability Supports and Services Non-Physician Appendix	3.1 Primary Care Office-Based Alcohol Treatment (OBAT)/Office-Based Opioid Treatment (OBOT) (new subsection)	New subsection text reads: Providers working in a primary care setting are permitted to seek fee for service (FFS) reimbursement for AUD and OUD services in an office-based setting. (Refer to the Office-Based Alcohol Treatment (OBAT)/Office-Based Opioid Treatment (OBOT) subsection in the Practitioner chapter for additional information regarding reimbursement provision.)
		Practitioner	14.2 Substance Use Disorder Services	The 1st paragraph was revised to read: Most substance use disorder (SUD) services provided to Medicaid beneficiaries are covered through the local PIHP/CMHSP. PIHPs/CMHSPs are responsible for direct payment for inpatient psychiatric or partial hospitalization services, related physician services, and specialized community mental health clinical and rehabilitation services that the PIHP/CMHSP has prior authorized. Providers should not bill MDHHS for these services. All providers are encouraged to utilize this system when and wherever possible.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				The table was removed and content was reformatted to the following new subsections: • 14.2.A. Acute Care Detoxification • 14.2.B. Medication-Assisted Treatment • 14.2.C. Office-Based Alcohol Treatment (OBAT)/Office-Based Opioid Treatment (OBOT) • 14.2.D. Additional Substance Use Disorder Services
			14.2.A. Acute Care Detoxification (new subsection)	With re-formatting of subsection 14.2, text previously contained in the table was relocated here.
			14.2.B. Medication-Assisted Treatment (new subsection)	New subsection text reads: MAT is the use of medications often used in combination with counseling and behavioral therapies to provide a whole-patient approach to the treatment of substance use disorders (SUDs). Medications used in MAT are approved by the Food and Drug Administration (FDA). MAT programs are clinically driven and tailored to meet each patient's needs. For additional information regarding MAT, refer to the Medication-Assisted Treatment (MAT) subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			14.2.C. Office-Based Alcohol Treatment (OBAT)/Office-Based Opioid Treatment (OBOT) (new subsection)	New subsection text reads: OBAT/OBOT services may be reimbursed directly by MDHHS when provided to MHP enrollees and FFS beneficiaries. Primary healthcare providers (which encompasses the following healthcare providers: Physicians [MD/DO], Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, Clinical Nurse Midwives, Obstetricians/Gynecologists, and Pediatricians) in an office-based setting who are licensed or otherwise trained to provide SUD services and behavioral health providers (Licensed Psychologist [doctoral level], Licensed Social Worker [master's level], Licensed Marriage and Family Therapist [master's or doctoral level], Licensed Professional Counselor [master's or doctoral level], Limited Licensed Psychologist [master's or doctoral educational level] under the supervision of an enrolled, fully-licensed psychologist [except as noted in Section 333.18223 of the Public Health Code] who are associated with them, and who do not have a specialty SUD benefit services contract with a PIHP) may be reimbursed through the Medicaid Fee for Service (FFS) program. OBAT/OBOT services provided by qualified providers, as identified above, will be considered for reimbursement through the FFS program when the beneficiary meets the American Society of Addiction Medicine (ASAM) criteria for outpatient treatment. Providers are required to provide services consistent with clinical practice guidelines established by the Substance Abuse and Mental Health Services Administration (SAMHSA) and ASAM.

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				The following services related to opioid use disorder (OUD) and alcohol use disorder (AUD) treatment will qualify for FFS reimbursement when a beneficiary meets ASAM criteria for outpatient treatment and has a primary diagnosis of opioid use, abuse and dependence or alcohol use, abuse and dependence as classified by the International Classification of Diseases, Version 10 (ICD-10): • Evaluation and Management services • Consultation services • Psychotherapy services • Psychiatric Collaborative Care Management services • Behavioral Health Care Management • Drug Testing services • Other Laboratory services • Screening, Brief Intervention and Referral to Treatment (SBIRT) • Medications for the treatment of AUD/OUD The treatment of AUD/OUD requires a multi-faceted and individualized approach to reach full treatment potential that may include screening and assessment, medications and medication management, and counseling and/or other psychosocial supports. To reach optimal treatment, beneficiaries must be actively involved in their treatment and, as such, it is important that all providers coordinate care. Beneficiaries with significant AUD or OUD may require assistance with transportation, housing, job resources, and other important life aspects that impact a beneficiary's recovery. Primary healthcare providers must ensure beneficiaries have access and receive referral to PIHPs for further assessment and treatment, and any of the other supports and services that are available (i.e., PIHP specialty services, community-based services, and natural supports) as needed to ensure desired treatment results.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				PIHPs/CMHSPs, FFS and MHPs must partner as needed in overseeing and coordinating the treatment plan, knowing that office-based AUD/OUD treatment may be only part of the services necessary to achieve successful outcomes. Participating providers must observe applicable State and Federal laws, rules, regulations, and policies, including Michigan Automated Prescription System (MAPS) prescribing requirements. Refer to the Directory Appendix for website information regarding MAPS. (Refer to the General Information for Providers Chapter for additional information on enrollment in CHAMPS.)
			14.2.D. Additional Substance Use Disorder Services (new subsection)	With re-formatting of subsection 14.2, text previously contained in the table was relocated here.
		Acronym Appendix		Addition of: AUD - Alcohol Use Disorder OBAT – Office-Based Alcohol Treatment OBOT - Office-Based Opioid Treatment OUD -- Opioid Use Disorder

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 21-20	7/16/2021	Behavioral Health and Intellectual and Developmental Disability Supports and Services	18.3 Comprehensive Diagnostic Evaluations	The 2nd paragraph was revised to read: The determination of a diagnosis by a qualified licensed practitioner is accomplished by direct observation, ~~and~~ utilizing ~~the Autism Diagnostic Observation Schedule Second Edition (ADOS-2),~~ valid evaluation tools, and by administering a comprehensive clinical interview including a developmental symptom history (medical, behavioral, and social history) such as the Autism Diagnostic Interview-Revised (ADI-R) or clinical equivalent. ~~In addition, a qualified licensed practitioner will rate symptom severity with the Developmental Disabilities Children's Global Assessment Scale (DD-CGAS).~~ Other tools should be used when a clinician feels it is necessary to determine a diagnosis and medical necessity service recommendations. Other tools may include: • cognitive/developmental tests, such as the Mullen Scales of Early Learning, Wechsler Preschool and Primary Scale of Intelligence-IV (WPPSI-IV), Wechsler Intelligence Scale for Children-IV (WISC-IV), Wechsler Intelligence Scale for Children-V (WISC-V), or Differential Ability Scales-II (DAS-II); • adaptive behavior tests, such as Vineland Adaptive Behavior Scale-II (VABS-II), Adaptive Behavior Assessment System-III (ABAS-III), or Diagnostic Adaptive Behavior Scale (DABS); and/or • symptom monitoring, such as Developmental Disabilities-Children's Global Assessment Scale (DD-CGAS), Social Responsiveness Scale-II (SRS-II), Aberrant Behavior Checklist, or Social Communication Questionnaire (SCQ).

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			18.5 Determination of Eligibility for BHT	The 1st paragraph was revised to read: The following is the process for determining eligibility for BHT services for a child with a confirmed diagnosis of ASD. Eligibility determination and recommendation for BHT must be performed by a qualified licensed practitioner through direct observation utilizing ~~the ADOS-2 and symptom rating using the DD-CGAS~~ valid evaluation tools. BHT services are available for children under 21 years of age with a diagnosis of ASD from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and who have the developmental capacity to clinically participate in the available interventions covered by BHT services. A well-established DSM-IV diagnosis of Autistic Disorder, Asperger's Disorder or PDD-NOS should be given the diagnosis of ASD. Children who have marked deficits in social communication but whose symptoms do not otherwise meet criteria for ASD should be evaluated for social (pragmatic) communication disorder.

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			18.7 Re-Evaluation	Text was revised to read: ~~An annual re-evaluation by a qualified licensed practitioner to assess eligibility criteria must be conducted through direct observation utilizing the ADOS-2 and symptoms rated using the DD-CGAS. Additional tools should be used if the clinician feels it is necessary to determine medical necessity and recommended services. Other tools may include cognitive/developmental tests, adaptive behavior tests, and/or symptom monitoring.~~ Comprehensive diagnostic re-evaluations are required no more than once every three years, unless determined medically necessary more frequently by a physician or other licensed practitioner working within their scope of practice. The recommended frequency should be based on the child's age and developmental level, the presence of comorbid disorders or complex medical conditions, the severity level of the child's ASD symptoms and adaptive behavior deficits through a person-centered, family-driven youth-guided process involving the child, family, and treating behavioral health care providers.
MSA 21-25	7/30/2021	Behavioral Health and Intellectual and Developmental Disability Supports and Services	19.5.A. Geographic Area	The following counties were added: • Genesee • Lapeer • Lenawee • Livingston • Monroe • Sanilac • St. Clair • Washtenaw • Wayne

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MSA 21-33	8/17/2021	Hospital Reimbursement Appendix	2.3.A.6. Special Circumstances	The following text was added to the table: **Rapid Whole Genome Sequencing** rWGS provided in the inpatient hospital setting prior to discharge is excluded from the DRG payment. An additional payment for the rWGS testing will be made to a hospital when clinical criteria are met and MDHHS authorization is obtained. Costs associated with the rWGS testing are to be billed separately from the inpatient visit using the 837P or CMS-1500 Professional claim format and are reimbursed according to the Medicaid laboratory fee screen.

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		Laboratory	**5**.5.D. Rapid Whole Genome Sequencing (new subsection)	New subsection text reads: Medicaid covers medically necessary rapid whole genome sequencing (rWGS) testing for the evaluation of critically ill infants admitted to an inpatient intensive care unit with a complex illness of unknown etiology. rWGS is medically necessary when **all** the following apply: • The beneficiary is one year of age or less; • The beneficiary's signs or symptoms suggest a rare genetic condition that cannot be diagnosed by a standard clinical work-up; • The beneficiary's signs and symptoms suggest a broad, differential diagnosis that could require multiple genetic tests if rWGS was not performed; • Timely identification of a molecular diagnosis is necessary in order to guide clinical decision making, and the rWGS results will guide the treatment and/or management of the beneficiary's condition; and • At least **one** of the following clinical criteria apply to the beneficiary: ➢ Multiple congenital anomalies ➢ Specific malformations highly suggestive of a genetic etiology ➢ An abnormal laboratory test suggests the presence of a genetic disease or complex metabolic phenotype (e.g., abnormal newborn screen, hyperammonemia, or lactic acidosis not due to poor perfusion) ➢ Refractory or severe hypoglycemia ➢ Abnormal response to therapy related to an underlying medical condition affecting vital organs or bodily systems ➢ Severe hypotonia ➢ Refractory seizures

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				➢ A high-risk stratification on evaluation for a Brief Resolved Unexplained Event (BRUE) with any of the following features: ▪ Recurrent events without respiratory infection ▪ Recurrent witnessed seizure-like events ▪ Required cardiopulmonary resuscitation (CPR) ➢ Abnormal chemistry levels (e.g., electrolytes, bicarbonate, lactic acid, venous blood gas, glucose) suggestive of inborn error of metabolism ➢ Abnormal cardiac diagnostic testing results suggestive of possible channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease ➢ Family genetic history related to beneficiary's condition rWGS is not covered when one of the following reasons explains the beneficiary's admission: • An infection or sepsis with normal response to therapy • Confirmed prenatal/postnatal genetic diagnosis consistent with the beneficiary's condition • Hypoxic-Ischemic Encephalopathy (HIE) with a clear precipitating event • Isolated prematurity • Isolated Transient Tachypnea of the Newborn (TTN) • Isolated unconjugated hyperbilirubinemia • Nonviable neonate • Trauma • Meconium aspiration

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			5.5.D.1. Provider Evaluation (new subsection)	New subsection text reads: Prior to ordering rWGS, the beneficiary must be evaluated by a medical geneticist or other physician sub-specialist with expertise in the conditions and/or genetic disorder for which testing is being considered. The consultation must be documented in the beneficiary's medical record and if performed via telemedicine, should follow all the requirements specified in Medicaid's telemedicine policy.
			5.5.D.2. Test Results (new subsection)	New subsection text reads: Generally, a preliminary test report from the performing laboratory should be provided to the beneficiary's ordering physician in less than seven days and a final report in less than 14 days. Hospitals should only utilize laboratories whose average expected turnaround time for rWGS processing meets these established time frames.
			5.5.D.3. Prior Authorization (new subsection)	New subsection text reads: rWGS requires MDHHS approval. Providers should refer to the Authorization Requirements and Documentation subsection in this chapter for submission instructions.

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			5.5.D.4. Billing and Reimbursement (new subsection)	New subsection text reads: Reimbursement for rWGS testing is available to Medicaid enrolled hospitals performing rWGS (directly or through a reference laboratory arrangement) when the test meets Medicaid's coverage guidelines and authorization is obtained. Costs associated with inpatient rWGS testing are excluded from the DRG payment and reimbursement will be made in accordance with the Medicaid laboratory fee screens. For Michigan Medicaid Health Plan (MHP) enrolled beneficiaries, rWGS testing services provided in the inpatient hospital setting prior to discharge are carved-out of the MHPs. Such services will be reimbursed by FFS per Medicaid policy.
		Acronym Appendix		Addition of: BRUE - Brief Resolved Unexplained Event HIE - Hypoxic-Ischemic Encephalopathy rWGS - rapid whole genome sequencing TTN - Transient Tachypnea of the Newborn

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MSA 21-38	11/1/2021	Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.G.2. Peer Specialist Services	Subsection text was revised in its entirety to read: Peer support specialists are individuals with a strong personal knowledge of what it is like to have first-hand lived experience with a mental health condition that has caused a substantial life disruption. A substantial life disruption is defined as experiencing some or all of the following: homelessness, mental health crises, trauma, lack of employment, criminal justice involvement, discrimination, stigma/prejudice intensified by mental health challenges, receiving public benefits due to poverty. Beneficiaries share mutual experiences in their journey of recovery with the peer support specialist. This mutuality is the foundation of what is referred to as "peerness" between a peer support specialist and a beneficiary seeking recovery, promoting connection, and offering hope. As a state and national expectation, peer support specialists are trained and skillful in sharing their recovery story as a method of engaging beneficiaries. Peer support specialists inspire hope and support others experiencing similar situations. Through shared understanding and respect, they support people to become and stay engaged in the recovery process. Serving in a role as a community health worker, they support the beneficiary with their personal wellness and recovery. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process. Peer support specialists assist people in recovery to connect with their own inner strength, motivation, and desire to move forward in life, even when experiencing challenges.

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				Peer support specialists provide services and supports based on medical necessity criteria that is designed to assist the beneficiary to achieve their goals of community inclusion and participation, independence, recovery, resiliency and/or productivity. This medical necessity criteria is included in the person-centered planning process; listed in amount, scope and duration, and documented in the individual plan of service. Depending on their position description that is developed specifically by each individual agency, services that peer support specialists provide may include: • Sharing their story through their lived experience of moving from hopelessness to hope; • Co-facilitation with the beneficiary in development and implementation of recovery goals in the individual plan of service completed through a person-centered planning process; • Integration of physical and mental health care, including the development of wellness plans; • Developing, implementing and providing health and wellness supports to address preventable risk factors for chronic conditions; • Advocate and assist with opportunities to engage in self-directed care; • Developing, implementing and facilitating support groups; • Providing supportive services during and after crises; • Supporting beneficiaries in completing psychiatric advance directives;

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				• Accessing benefits and utilizing public assistance; • Navigating challenging and complex systems of care; • Linking and engaging the beneficiary to community resources and formal/informal supports; • Vocational assistance and support; • Promoting, improving and educating whole health and self-management of chronic conditions; • Housing assistance and support; • Active engagement with individuals who have criminal justice involvement; • Applies and models the five stages of recovery to assist beneficiaries in achieving their personal recovery goals As an evidence-based practice, peer support is valuable not only for the person receiving services but also for behavioral health and integrated care professionals, including the systems in which they work. Peer support specialists educate their colleagues and advocate for and advance the field by sharing their perspectives, recovery stories, and experience in order to increase understanding of how recovery practices and policies may be improved to promote health and wellness. Research and experience show that peer support specialists have a transformative effect on both individuals and systems. Peer support has been shown to improve quality of life, improve engagement and satisfaction with services and supports, improve whole health -- including chronic conditions, decrease hospitalizations and inpatient days, and reduce the overall cost of services.

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				Supervision Requirements The Centers for Medicare & Medicaid Services (CMS) requires that peer support specialists be supervised by a Qualified Mental Health Professional (QMHP) as defined by the Health and Aging Services Administration. The amount, duration and scope of supervision can vary depending on the demonstrated competency and experience of the peer support provider, as well as the service array, and may range from direct oversight to periodic care consultation. **Certification Requirements** Individuals who are working as peer support specialists in a Medicaid service delivery system serving beneficiaries with mental health conditions must: • Be at least 18 years of age; • Have a high school diploma, General Education Diploma (GED), or provide college transcripts in lieu of a high school diploma or GED; • Have a primary diagnosis of a mental health condition; • Have a strong personal knowledge of what it is like to have first-hand lived experience with a mental health condition that has caused a substantial life disruption;

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				• Have been a recipient of mental health treatment and/or services for at least one year, with a substantial life disruption due to their mental health condition; • Have personal experience in navigating complex mental health treatment services; • Self-identify as having a mental health condition with a substantial life disruption and share their recovery story in supporting others; • Be employed by a CMHSP or contract provider at the beginning of training; • Meet the MDHHS application approval process for specialized training and certification: ➢ Completed peer support specialist application ➢ Supervisor signature and acknowledgment form ➢ Two written letters of reference ➢ Current job description ➢ Read, understand, and agree to peer code of ethics ➢ Acknowledgement of truthfulness and accuracy of application ➢ Peer-to-peer interview ➢ Training fee paid by the agency that employs the peer support specialist; • Attend professional advancement opportunities to maintain skills; • Be freely chosen by beneficiaries utilizing peer support services; and • Adhere to the MDHHS Peer Support Specialist Code of Ethics.

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MSA 21-44	12/1/2021	Dental	6.1.G.6. Radiograph Submission Requirements for Prior Authorization	The following text was added after the 1st paragraph: Providers should not send radiographs with PA requests for complete or partial dentures. Radiographs that are not specifically requested by MDHHS may not be returned to the provider. In the 2nd paragraph, the 1st bullet point was removed. • ~~Full mouth/complete series radiographs are required when submitting the MSA-1680-B for partial dentures.~~
			6.6.A. General Instructions	The 4th paragraph was revised to read: ~~Full mouth/complete series radiographs must be submitted with PA requests for partial dentures. Radiographs are not required to be submitted with PA requests for complete dentures.~~ Providers should not send radiographs with PA requests for complete or partial dentures. Radiographs that are not specifically requested by MDHHS may not be returned to the provider. MDHHS reserves the right to request radiographs if necessary. The following information must be submitted with the MSA-1680-B:

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 21-46	12/1/2021	Early and Periodic Screening, Diagnosis and Treatment	9.11 Hepatitis C Virus (HCV) Infection Screening (New subsection; following subsections were re-numbered)	New subsection text reads: All individuals should be screened for a hepatitis C virus (HCV) infection at least once between 18 and 79 years of age. These screenings, provided for individuals under 21 years of age, are considered an EPSDT service. Individuals at increased risk of HCV infection, including those with past or current injection drug use, should be tested for HCV infection and reassessed annually. An HCV infection screening may be provided to any individual requesting the screen regardless of their disclosure of risk since there may be reluctance to disclose these risks. For individuals identified with HCV infection, it is recommended that they receive appropriate care, including HCV clinical preventive services (e.g., screening and intervention for alcohol or drug use, hepatitis A and hepatitis B vaccination, and medical monitoring of disease). EPSDT services include the coverage of any follow-up services and referrals that are medically necessary to treat an HCV infection. Individuals with HCV infection should be provided information about treatment options, how to prevent transmission of HCV to others, and drug treatment, as appropriate.
		Acronym Appendix		Addition of: HCV – hepatitis C virus

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MSA 21-47	12/1/2021	Federally Qualified Health Centers	Section 4 – Billing	The 4th paragraph was reformatted and revised to read: The NPI (Type 1 – Individual) number of the ~~physician (MD or DO)~~ practitioner overseeing the beneficiary's care must be entered as the attending provider. The attending provider field is mandatory to complete. The following providers may be reported in the attending provider field: • Physicians (includes dentists, podiatrists, optometrists, and chiropractors) • Nurse Practitioners • Physician Assistants • Certified Nurse Midwives • Clinical Psychologists • Clinical Social Workers • Clinical Nurse Specialists • Licensed Psychologists (Doctoral Level) • Social Workers (Master's Level) • Professional Counselors (Master's or Doctoral levels) • Marriage and Family Therapists • Limited Licensed Psychologists (Master's or Doctoral Level) Additionally, the NPI (Type 1 – Individual) number of the practitioner who performed the service should be entered as the rendering provider. Do not enter a Group (Type 2) NPI number as the attending or rendering provider.

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		Rural Health Clinics	6.1 Billing Rural Health Clinic Services	The 4th paragraph was reformatted and revised to read: The NPI (Type 1 – Individual) number of the ~~physician (MD or DO)~~ practitioner overseeing the beneficiary's care must be entered as the attending provider. The attending provider field is mandatory to complete. The following providers may be reported in the attending provider field: • Physicians (includes dentists, podiatrists, optometrists, and chiropractors) • Nurse Practitioners • Physician Assistants • Certified Nurse Midwives • Clinical Psychologists • Clinical Social Workers • Clinical Nurse Specialists • Licensed Psychologists (Doctoral Level) • Social Workers (Master's Level) • Professional Counselors (Master's or Doctoral levels) • Marriage and Family Therapists • Limited Licensed Psychologists (Master's or Doctoral Level) Additionally, the NPI (Type 1 – Individual) number of the practitioner who performed the service should be entered as the rendering provider. Do not enter a Group (Type 2) NPI number as the attending or rendering provider.

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		Tribal Health Centers	Section 7 – Billing	The 2nd paragraph was reformatted and revised to read: The NPI (Type 1 – Individual) number ~~is the individual who has overall responsibility for the patient's medical care and treatment reported in the claim or encounter~~ of the practitioner overseeing the beneficiary's care must be entered as the attending provider. The attending provider field is mandatory to complete. The following providers may be reported in the attending provider field: • Physicians (includes dentists, podiatrists, optometrists, and chiropractors) • Nurse Practitioners • Physician Assistants • Certified Nurse Midwives • Clinical Psychologists • Clinical Social Workers • Clinical Nurse Specialists • Licensed Psychologists (Doctoral Level) • Social Workers (Master's Level) • Professional Counselors (Master's or Doctoral levels) • Marriage and Family Therapists • Limited Licensed Psychologists (Master's or Doctoral Level) Additionally, the NPI (Type 1 – Individual) number of the practitioner who performed the service should be entered as the rendering provider. Do not enter a Group (Type 2) NPI number as the attending or rendering provider.
MSA 21-48	12/2/2021	MI Choice Waiver		The chapter was replaced with the new version.

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		Directory Appendix	MI Choice Waiver Resources	Addition of: Contact/Topic: Home Delivered Meals Guidelines and Other Required Documents Mailing/Email/Web Address: www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Services for Seniors >> MI Choice Waiver Program >> MI Choice Waiver Documents and Provider Information Information Available/Purpose: Home Delivered Meals Guidelines, Person-Centered Planning Guidelines, HCPCS Codes, NOC/NOC Code Document, Provider Monitoring Tool, residential and non-residential setting surveys, Self-Determination Guidance
MSA 21-51	12/29/2021	Tribal Health Centers	4.1 Requirements for Participation	Text was revised to read: All programs must meet the following criteria to bill Medicaid for services: • ~~Licensed by the state licensing agency to provide each type of substance abuse service; and~~ • Accredited as an alcohol and/or drug abuse program by one of the five national accreditation bodies: ➢ The Joint Commission ➢ Commission on Accreditation of Rehabilitation Facilities (CARF) ➢ American Osteopathic Association (AOA) ➢ Council on Accreditation of Services for Families and Children (CASFC) ➢ National Committee on Quality Assurance (NCQA)
MSA 21-52	12/29/2021	Home Help (new chapter)		Addition of new Home Help chapter.

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		Acronym Appendix		Addition of: ASM - Adult Services Manual ASW - adult services worker ESV - electronic service verification FICA - Federal Insurance Contributions Act IRS - Internal Revenue Service OIG - Office of Inspector General PSV - paper service verification SIGMA VSS - State of Michigan Statewide Integrated Governmental Management Application Vendor Self Service system USC - United States Code W-2 - IRS Form W-2 Wage and Tax Statement

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		Directory Appendix	Home Help (new section)	Addition of: **Contact/Topic:** Adult Services Manual Table of Contents **Web Address:** https://dhhs.michigan.gov/OLMWeb/ex/AS/Public/ASM/000.pdf **Information Available/Purpose:** Includes hyperlinks to all sections of the Adult Services Manual referenced in the Home Help chapter. To access an ASM, click on its Manual/Code number or Title. **Contact/Topic:** Centralized Intake for Abuse and Neglect **Phone # Fax #:** 855-444-3911 **Information Available/Purpose:** To make an oral report regarding suspected abuse, neglect or exploitation of adults. **Contact/Topic:** Home Help Webpage **Web Address:** www.michigan.gov/homehelp **Information Available/Purpose:** Includes information about applying to become a Home Help provider, documenting and billing services, payment rates and schedules, CHAMPS enrollment, and receiving automatic updates on Home Help policies and procedures. **Contact/Topic:** Local MDHHS Offices **Web Address:** www.michigan.gov/mdhhs >> Inside MDHHS >> County Offices **Information Available/Purpose:** Contact information for MDHHS adult services staff.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Contact/Topic: New Agency Application **Phone # Fax #:** Fax: 517-241-0067 **Email Address:** MDHHS-HHProviderQuestions@michigan.gov **Mailing Address:** Michigan Department of Health and Human Services MDHHS Home Help Policy Section P.O. Box 30479 Lansing, MI 48909 **Information Available/Purpose:** To submit an application to become an approved agency provider. **Contact/Topic:** New Agency Provider Compliance Review and Agency Provider Audits **Phone # Fax #:** Fax: 517-241-0067 **Email Address:** MDHHS-MSA-HHProviderReporting@Michigan.gov **Mailing Address:** Michigan Department of Health and Human Services MDHHS Home Help Policy Section P.O. Box 30479 Lansing, MI 48909 **Information Available/Purpose:** To submit required documents for an audit.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Contact/Topic: Paper Service Verification (PSV) **Phone # Fax #:** Fax: 517-763-0111 **Mailing Address:** MDHHS Adult Home Help P.O. Box 26007 Lansing, MI 48909 **Information Available/Purpose:** To submit a PSV for payment. **Contact/Topic:** Request for Reinstatement as an Approved Agency Provider **Email Address:** MDHHS-MSA-HHProviderReporting@Michigan.gov **Information Available/Purpose:** To request reinstatement of approved agency provider status and payment rate. **Contact/Topic:** Statewide Integrated Governmental Management Application Vendor Self Service system (SIGMA VSS) **Phone # Fax #:** Phone: 888-734-9749 **Email Address:** To receive assistance from the SIGMA Vendor Help Desk: SIGMA-Vendor@michigan.gov **Web Address:** To create a vendor account with the State of Michigan: www.michigan.gov/vsslogin **Web Address:** To manage payment information and view financial transactions: www.Michigan.gov/SIGMAVSS **Information Available/Purpose:** SIGMA VSS is the payment portal for agency providers.

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				Contact/Topic: Voluntary Provider Disenrollment **Email Address:** MDHHS-MSA-HHProviderReporting@Michigan.gov and providerenrollment@michigan.gov **Information Available/Purpose:** To disenroll as a Home Help provider.
		Forms Appendix		Addition of: DHS-390 - Adult Services Application DHS-54A - Medical Needs HASA-2104 - Home Help Agency Provider Employment Requirements MSA-1904 - Home Help Agency Invoice MSA-204 - Home Help Agency Caregiver Enrollment Authorization

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
HASA 22-03	2/8/2022	Billing & Reimbursement for Institutional Providers	7.28 Therapies (Occupational, Physical, and Speech-Language)	The 1st paragraph was reformatted and revised to read: Therapy services must be reported using the appropriate procedure code and therapy modifier to distinguish the ~~discipline~~ plan of care under which the service is delivered. In addition, when services are habilitative, they must be billed with the appropriate modifier that represents the nature of the therapy performed. Outpatient hospital facility providers must also report the appropriate therapy assistant modifier when services are furnished in whole or in part by a physical therapy or occupational therapy assistant. In cases where both a physical or occupational therapist and a physical or occupational therapist assistant (PTA/OTA) provide a portion of the same untimed service or 15-minute timed unit of service, Medicaid will utilize Medicare's *de minimis* standard in determining if the service/unit is considered to be furnished in whole or in part by a PTA or OTA. For MHP enrollees, the provider should check with the MHP for PA requirements. Refer to the Therapy Services chapter for additional information related to therapies.

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		Therapy Services	1.5 Therapy Services	Text was reformatted and revised to read: Therapy claims must be submitted using the appropriate procedure code and therapy modifier to distinguish the ~~discipline~~ plan of care under which the service is delivered. To differentiate between habilitative and rehabilitative therapy, when services are habilitative, report with the appropriate modifier that represents the nature of the therapy being performed. Only Medicaid beneficiaries under 21 years of age and Healthy Michigan Plan beneficiaries may be eligible for medically necessary habilitative therapy services. In addition to these modifiers, maintenance therapy services should be billed with the MDHHS identified modifier to categorize the service as maintenance related. Therapy services submitted without these modifiers may be denied. Outpatient hospital facility providers must also report the appropriate therapy assistant modifier when services are furnished in whole or in part by a physical therapy or occupational therapy assistant. In cases where both a physical or occupational therapist and a physical or occupational therapist assistant (PTA/OTA) provide a portion of the same untimed service or 15-minute timed unit of service, Medicaid will utilize Medicare's *de minimis* standard in determining if the service/unit is considered to be furnished in whole or in part by a PTA or OTA. Refer to the Billing and Reimbursement chapters in this manual for additional modifier information.